Casework and Service Delivery Policy

Independent Living Rehabilitation Services

North Carolina Vocational Rehabilitation Services

Effective July 10, 2010

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MANUAL INTRODUCTION

All policies stated in this manual are effective July 1, 2010 and replace Independent Living Rehabilitation Program policy and procedural information issued for Volume I prior to this date. Subsequent revisions of this Volume will have a revision date. Unless otherwise specified, all policies relate to the Independent Living Rehabilitation Program.

This manual is divided into chapters based on the rehabilitation process of the Independent Living Rehabilitation Program (IL) of the North Carolina Division of Vocational Rehabilitation Services. Each chapter is divided into sections with many sections divided further into subsections. Each chapter, section, and subsection is numbered to provide for easy location of specific topics. A Table of Contents and an Index identifying the location of each topic is also provided.

An Appendix is provided which gives the reader general information and guidance on topics supporting the rehabilitation process.

CHARGE AND PURPOSE OF THE NORTH CAROLINA DIVISION OF VOCATIONAL REHABILITATION SERVICES

Our Charge:

North Carolinians with disabilities will live and work in the communities of their choice with economic and other supports available to help them achieve and maintain optimal self-sufficiency and independence.

Our Purpose:

To promote employment and independence for people with disabilities through customer partnership and community leadership.

CHAPTER ONE: PROGRAM ADMINISTRATION

Section 1-1: Introduction

Enabling Legislation

Federal Legislation and Administration

Title I and Chapter I of Title VII of the Rehabilitation Act of 1973, Public Law 93-112, as amended by Public Laws 93-516, 95-602, 98-221, 99-506, 100-630, 102-569, 103-73, and 105-220.

The Vocational Rehabilitation Program and the Independent Living Program are administered by the Rehabilitation Services Administration in the U. S. Department of Education.

State Legislation and Administration

N. C. General Statutes 143-545.1.

The Department of Health and Human Services is required to establish and operate these programs under the administration of the Division of Vocational Rehabilitation Services in collaboration with the Division of Services for the Blind which conducts Vocational Rehabilitation and Independent Living programs for individuals who are blind or visually impaired under Chapter III of the General Statutes.

State Plans

To be eligible to receive Federal funds for its programs, the State must have a State Plan for Vocational Rehabilitation Services with a Supplement for Supported Employment Services and a State Plan for Independent Living that meet Federal requirements.

[The Rehabilitation Act of 1973 (P.L. 93-112) as amended through 1998; G.S. 143-545.1]

1-1-1: Policy Development and Consultation

The Division of Vocational Rehabilitation Services shall seek and consider in connection with general policy development and implementation the views of:

A. Current and former clients or, as appropriate, their parents, guardians or other representatives;
B. Providers of vocational rehabilitation and independent living services;
C. The State Rehabilitation Council;
D. The Statewide Independent Living Council;

E. Representatives of business and industry and other employers;
F. Numerous advocacy and consumer organizations;
G. Other councils, commissions, associations, agencies, and departments concerned with issues related to individuals with disabilities; AND
H. Committees representing counselors, members of the regional rehabilitation centers, and other professional groups.

Implementation of this policy shall involve the use of numerous mechanisms to seek such views including, but not limited to the following:

- STATE AND STRATEGIC PLAN PUBLIC MEETINGS throughout the State, after appropriate and sufficient notice (usually thirty days), to allow interested individuals and groups an opportunity to comment on the Vocational Rehabilitation and Independent Living State Plans and the Division's Strategic Plan and to participate in the formulation of policies governing the provision of service established through these plans as required by the Federal Vocational Rehabilitation Law.

- PUBLIC RULE-MAKING HEARINGS which are required by the State's Administrative Procedure Act, G.S. 150B, prior to the adoption of policies or procedures that affect the public and that are not already established in either State or Federal laws or rules. These rule-making hearings involve a lengthy process that involves 30-day notices, submission and analysis of fiscal impact of the policies by the Office of State Budget and Management and review by the Governor's Office, an Administrative Rules Review Committee, and the Joint Legislative Administrative Procedures Oversight Committee. This law also provides legal avenues for court review of statutory authority for policies and procedural safeguards for the public.

- ADVICE AND COLLABORATION WITH THE STATEWIDE INDEPENDENT LIVING COUNCIL: Federal law requires the Division and the Division of Services for the Blind to jointly develop and sign the Independent Living State Plan with the Statewide Independent Living Council, and to secure the involvement of this Council in the development of the Strategic Plan. The Independent Living Council is required by Federal law; and in North Carolina, the Governor appoints its 29 members some of whom represent the Division of Services for the Blind.

- INVOLVEMENT OF THE CLIENT ASSISTANCE PROGRAM (CAP) in policy development. The Director of CAP is a member of the Division's Management Team and has the opportunity to participate in initial discussions as policy is being developed. In addition, the Director is a member of the State Rehabilitation Council and regularly attends meetings of the Statewide Independent Living Council, thus representing client

interests in policy development through these two bodies as well as public hearings. CAP is also able, through its involvement in the Division's administrative review/appeals process, to identify problematic policy issues and call these to the attention of the Division Director.

- CONDUCTING FOCUS GROUPS: These groups are a source of stakeholders' participation in policy development, particularly in identifying areas of concern related to existing or needed policies. Focus groups are conducted under the direction of local unit offices and represent grass-roots involvement in policy development.

- DIRECTOR'S INFORMAL CONSULTATION WITH CONSUMER AND ADVOCACY GROUPS: The Division Director periodically holds informal meetings with leaders of various consumer and advocacy groups to solicit their concerns about needed policies or policy changes. These meetings usually relate to significant service-delivery issues such as order of selection for services or issues that would be appropriate for the State or Strategic Plans.

- NORTH CAROLINA ASSOCIATION OF REHABILITATION FACILITIES: The Division Director or his designee meets with the executive committee of this group (which represents community rehabilitation programs) at their regularly scheduled meetings and occasionally, as the need arises, will request special meetings with them. These meetings provide an opportunity for the group to have input into policy development and change.

- COUNSELOR ADVISORY COMMITTEE (CAC): The Counselor Advisory Committee is a group of representatives elected by counselors from all the unit offices and facilities across the State. It meets at least three times a year with the Assistant Director for Program Operations and other supervisory and management staff as appropriate. Ideas, needs, feelings, and client-related issues from the Committee are presented to the Division Director through the Assistant Director. Many of the issues raised by this group result in policy studies and possible changes.

- CONTACT WITH OTHER ORGANIZATIONS, AGENCIES, ASSOCIATIONS, COUNCILS, AND COMMISSIONS: The Division maintains formal contact with approximately 50-75 groups other than those specifically described in this policy. In some instances, the Division has formal representation on such bodies. In other instances, information is routinely exchanged through informal contact, formal correspondence, public hearing notices, and newsletters. The Division has a mailing list of approximately 600 groups and individuals who receive all hearing notices and all proposed rules in addition to hearing notices regarding the two State Plans and the Strategic Plan.

- SPECIAL STUDIES AND SURVEYS are used to solicit direct consumer input that assists in evaluating the Division's delivery of services and the policies guiding that service delivery.

- THE CONSUMER SATISFACTION SURVEY CONDUCTED BY THE STATE REHABILITATION COUNCIL is used to evaluate the effectiveness of, and consumer satisfaction with, rehabilitation services received through the Division's Title I program. It is sent to all clients who received services from the general Vocational Rehabilitation program and whose cases have been closed within 60 days of their case closure. Review and analysis of these survey results provide information that can assist in evaluating Division policy and implementation of such policy.

- THE INDEPENDENT LIVING REHABILITATION PROGRAM SATISFACTION SURVEY is a similar survey used by the Independent Living Program. It is sent to all consumers in the Independent Living program who have achieved their Independent Living goals within 30 days of the closure of the consumer's case. Results of these surveys can also assist in evaluating policy and its implementation.

- THE POST-CLOSURE FOLLOW-UP STUDY is an ongoing study in which a sample of individuals whose cases were closed successfully is contacted 12 months after their cases are closed. Current work status, earnings, and client views regarding services are assessed by means of a survey form. This information is also useful in evaluating policy and its long-range implications.

[34 C.F.R.361.20; 34 C.F.R.364.20; I.L. State Plan Section 2.3]

1-1-2: Audit-Federal

The Department of Education requires that State Vocational Rehabilitation Division records including client files be retained for three years. Therefore, Federal auditors when auditing the Division, review active client files or records which have been closed no longer than three years. The Division by State statute retains closed case files until notified by the Office of the Controller that cases closed in a specific year are scheduled for disposition. Refer to policy in 1-2-4.

1-1-3: Provision of Services to Employees or to Members of Their Immediate Family

Policy does not prevent rehabilitation services from being provided to an applicant or client with a disability who is an employee or relative of an employee. Counselors should not complete Division documents or issue authorizations for any services for a family member, relative, or division employee without following the requirements set forth in this policy.

An immediate family member is defined as an employee's spouse, parent, sibling, child, grandparent, grandchild, aunt, uncle, and first cousins by either blood or marriage. Step and in-law relationships within these categories are also included as are others who may be living in the same household but unrelated. An employee is defined as anyone currently on Division payroll.

In the instance of an employee's family member or an employee, a neutral counselor or supervisor shall be asked to complete the preliminary assessment and forward such to the Regional Director who will make the eligibility decision and issue the IL Eligibility Decision. The Regional Director will then appoint a neutral counselor, working in a different unit office from the family member, to develop the rehabilitation program and provide services.

1-1-4: Transportation of Clients-Liability

A Division employee who has a motor vehicle accident while transporting a client in the employee's personal vehicle and injures the client is wholly liable, if the Division employee is found negligent. Even though the individual is a State employee and is engaged in State business at the time, this fact does not alter the liability issue.

If the client sustains injury while being transported in a State owned vehicle, and the Division employee is found negligent, liability insurance carried by the State would be available to help satisfy any allowed claim. Allowed claims in excess of State provided coverage become the employee's responsibility. Unless one's policy contains special provisions to cover such, it is our understanding liability insurance carried by the Division employee would not offer coverage when an accident involves a State owned vehicle.

When authorizing a third party to provide transportation for our clients, the counselor should confirm that the individual authorized has a valid driver's license, unless a commercially licensed person or firm is the authorized carrier.

Should a Division employee be involved in any accident on the job which involves a client and/or a State owned vehicle, the employee's supervisor or the state office should be immediately notified.

[Attorney General Ruling]

Section 1-2: Records Management

All Division records of service must be maintained in a neat and orderly fashion which allows easy access to information regarding the client. Client records must be stored in locked file cabinets in each office and should not be removed from the office unless great care is taken to assure confidentiality of client information and should not be left unattended.

1-2-1: Record of Service Transfers

The transfer of client records of service should occur when another counselor is in a better position to develop or continue the rehabilitation program. Records should be transferred on the following conditions:

A. When an applicant/client has permanently located in a geographical area not served by the original counselor and a substantial amount of time is required to develop or complete the rehabilitation program;
B. When the applicant/client could best be served by a specialized counselor in the same geographical area, and if it is in the client's best interest;
C. When a client is being discharged from a facility and the facility does not have an assigned counselor to ensure completion of the rehabilitation process; OR
D. At client request and management discretion, a client's record may be transferred to another counselor when communication and rapport between a client and counselor is not at a level appropriate to assure successful completion of the rehabilitation program.

1-2-2: Responsibilities of the Transferring Counselor

The transferring counselor should communicate with the receiving counselor to acquaint the counselor with the client and:

1. Ensure the case record is in proper order and complete for the phase of the rehabilitation process. Records should be up-to-date regarding the client's address and telephone number along with references.
2. Notify the client of the pending transfer. This should be done via letter with a copy maintained in the client record. The letter should include the receiving counselor’s name, address and telephone number;
3. VR/IL program staff should make the appropriate changes via on-line data.
4. Transfer the case record within five days of the date of client notification.

1-2-3: Responsibilities of the Receiving Counselor

1. Transferred client records and clients must always be accepted. If casework deficiencies are noted, the receiving counselor will assume the responsibility for assuring the problems are corrected. Counselors should staff the case with their Unit Manager/Facility Director and proceed as indicated.
2. Arrange to meet the client as soon as possible but within thirty days after an accurate, up-to-date case record has been received.
3. When the client is being discharged from a rehabilitation center or facility, the receiving counselor should plan to meet with the client prior to the client's discharge.
4. Respond to any written queries regarding the client from the transferring counselor.
5. If appropriate, provide feedback to transferring counselor at time of case closure. A copy of the closure IPE/IPIL will suffice for feedback purposes. A letter is sufficient for records closed prior to the development of the IPE/IPIL.

[34 CFR 361.38 (Protection, use and release of personal information)]

1-2-4: Retention/Disposal of Records of Service

The Department of Health and Human Services and State Department of Cultural Resources, Division of Archives and History have agreed to a schedule for retention and disposition of records for the Division of Vocational Rehabilitation Services.

The following records are subject to the schedule of retention and disposition provided by the Office of the Controller. A predefined period of time cannot be used as a record disposition date. Staff will receive the schedule for purging and destroying records on a semiannual basis from the Chief Operations Officer. Records must be retained in the office until staff is notified that records closed during a specific year are scheduled for disposition. In addition, all records with litigation, appeals, and financial or other local issues pending when disposition is scheduled must be retained until those issues are completely resolved.

ACTIVE RECORDS OF SERVICE: Includes referral information, client data sheets, client survey forms, authorizations, eligibility/ineligibility decision, rehabilitation plans and amendments, financial statements, medical reports, case notes, and related documents and correspondence. Remove the record of service from active files once the record has been closed.

CLOSED RECORDS OF SERVICE: Includes case records closed from

any active status.

INELIGIBLE RECORDS OF SERVICE: Included in this category are those records of applicants who were not accepted for services.

PURCHASE ORDERS AND INVOICES

In addition, please retain and dispose of the following records as follows:

- CLIENT MASTER LIST: Keep in office two years, and then destroy.
- GENERAL OFFICE FILES: Includes applications for employment, personnel files, general memoranda, equipment inventory lists, purchase orders and invoices for supplies and equipment. These files should be arranged alphabetically by subject.
- EQUIPMENT INVENTORY LISTS AND GENERAL MEMORANDA: Keep until obsolete, then destroy

[Chapter l2l and l32 of the General Statutes of North Carolina]

1-2-5: Annual Review of Closed Records of Service

The Division is required by Federal law and regulations to conduct periodic reviews of certain categories of ineligibility determinations for applicants and clients. The review of ineligibility determinations applies to applicants who were determined ineligible, on the basis of assessments, which indicated they could not be expected to reach the rehabilitation goal due to the severity of the disability or unfavorable medical prognosis. The following policies apply as appropriate in the respective instances:

Client's Record of Service Closed as Ineligible Due to Unfavorable Medical Prognosis or Disability Too Severe

Clients closed as ineligible in case status code 58, 78, or 80 because the disability is too severe or there is an unfavorable medical prognosis (IL reason code 85) will be reviewed within 12 months to determine if circumstances resulting in the ineligibility decision have changed to the degree that the decision can be reversed. State office staff for the IL program will automatically conduct this initial review. Subsequent reviews will be conducted only upon request of the applicant.

The Program Policy, Planning, and Evaluation Services section or the IL program staff will mail a letter during the ninth month following the date of closure informing the applicant of their right to a review. This letter will also explain why the record was closed. A copy of this letter will be forwarded to the counselor currently serving the caseload from which the applicant was closed. This letter is designed to provide the applicant with a clear understanding of, and an opportunity for, review.

The letter will explain:

A. The Division's review responsibility;

B. That if the applicant feels employment/independence is now or in the near future a possibility, then the applicant should contact the counselor/office noted in the correspondence; AND

C. That if the applicant is uncertain of the future, contact in subsequent years may be requested.

If the applicant does not respond by the thirteenth month after closure, then the following options are available:

A. If the letter is returned (i.e., moved - no forwarding address; occupant unknown, etc.), the Division will have made a reasonable attempt to provide the initial review and the applicant's name will be dropped from any future follow-up list. Upon receipt of the returned letter from the postal service, the Program Policy, Planning, and Evaluation Services Section or the IL program will send the letter to the counselor. The letter will be filed in the applicant's case record.

OR

B. If the applicant fails to make contact by the thirteenth month, the applicant will be dropped from the list for future contact. The counselor shall document on the copy of the letter that no contact occurred and file the letter in the record of service.

If the applicant makes contact, the counselor should respond and interview the applicant and provide the assessments necessary to make a determination of eligibility based on current data. The applicant's other option would be to request a review the following year. Should either of these situations occur, the counselor must note at the bottom of the file copy of the letter one of the following:

- *Contact - case record requires no further consideration.*
- *Contact - case placed in 52 and subsequently placed in 60 (as appropriate). Counselor should identify the previous and new VR/IL number.*
- *Contact - case placed in 52 and not accepted (58).*
- *Counselor should identify the old and new IL number.*
- *Contact - applicant unable to participate in a rehabilitation program leading to work or independence - requests follow-up next year. (This will automatically establish a review the following year.)*

The IL counselor should notify the IL program staff. The copy of the letter should be filed in the new record. This step is very important in that it

allows the Division to document compliance with the Act.

The situation may arise when a record of service was closed 58, 78, or 80 for reason code 85 but is later referred or otherwise opened. IL staff should notify the IL program staff in the state office. This mechanism will prevent a follow-up letter being mailed during subsequent reviews.

[34 CFR 364.53]

1-2-6: Annual Verification of Records of Service

Each year the Regional Director will coordinate a "hands-on" comparison of the *Client Master List* with client records in each unit. This includes inactive and active records of service based on the *Client Master List.* The Regional Director will report to the Section Chief of Program Policy, Planning, and Evaluation or the Chief of Community Services by August 31 the results of the review. Every effort should be made to account for misplaced client records of service. Lost records of service should be reported to the Chief of Policy, as appropriate, for reconstruction purposes.

[34 CFR 361.39 and 34 CFR 361.49]

Section 1-3: Confidentiality of Records

All Division records of service will be maintained in a confidential manner as described in this section.

1-3-1: General Provisions

The Division, through its units and facilities, shall maintain a record on all clients receiving services from the Division. All records shall be of a confidential nature and shall not be made available to the general public. Except as required or allowed in this policy, no information obtained concerning a client served by the Division may be disclosed by the Division without the consent of that client. The Division will not contract with vendors who require, as a condition of admission, the disclosure of health or disability information which is not necessary to achieve health, safety, or programmatic objectives. For example, residential programs are not legally seen as settings that should require HIV disease related information for health and safety reasons. In situations when such disclosure is necessary, the Division will require that the vendor have in place policies which assure that such information will be used and disclosed only as necessary to achieve those purposes. If the information concerns a minor, the consent of a parent or guardian must also be obtained. After a client has reached the age of l8 years, the records of that client may be disclosed only with the consent of that client, or, if the client is incompetent, the client's guardian. Furthermore, whenever consent or action is required of a client, the client's representative, if

properly authorized, may give such consent or take such action.

Except as provided in this policy, each Division client shall have full access to all records which contain information regarding the client. A parent or guardian of a minor shall also have full access to the information contained in the records of that minor. All clients, representatives, service providers, cooperating agencies, and interested persons shall be informed of the confidentiality of client personal information and the conditions for accessing and releasing this information.

All applicants/clients or their representatives must be informed about the Division's need to collect personal information and the policies governing its use. The Division shall inform clients of the following:

A. Identification of the Rehabilitation Act as the authority under which information is collected;
B. The principal purposes for which the Division intends to use or release the information;
C. That the applicant/client's provision of any information is mandatory if such information is necessary to determine eligibility, to plan rehabilitation goals, objectives, and services, and to accomplish the rehabilitation program. Failure to provide such information will result in delay or denial of services. Information which is not crucial or pertinent to the rehabilitation program would be deemed voluntary and would not affect provision of services if not provided by the client;
D. Identification of other agencies to whom information may be released along with the types of information so released; AND
E. Of those situations when the Division requires or does not require informed written consent of the client before information may be released.

All explanations to applicants/clients and their representatives about policies and procedures affecting confidential information must be in the applicant/client's primary language or must be through appropriate modes of communication for those individuals who rely on special modes of communication.

All confidential information acquired by the Division is the property of the Division and shall remain so, and all contracts, grants, agreements, and other documents entered into by the Division shall so provide. The Division shall maintain in its records only such information about a client as is relevant and necessary to accomplish any purpose of the Division required by statute or rule. No information in the case record shall be removed, destroyed, or altered for purposes of avoiding compliance with this policy. Whenever the Division makes a disclosure to any person or entity other than the client, the disclosed material shall be stamped with a *CONFIDENTIAL INFORMATION* stamp or accompanied by a letter containing the following statement**:** *THIS IS CONFIDENTIAL INFORMATION FROM THE RECORDS OF THE NORTH CAROLINA DIVISION OF VOCATIONAL REHABILITATION SERVICES. FEDERAL LAW AND*

REGULATIONS PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION WITHOUT THE INFORMED WRITTEN CONSENT OF THE CLIENT TO WHOM THIS INFORMATION PERTAINS.

The original file may not be removed from the control of the Division, but must be viewed in the office in the presence of a Division staff member. All other responses to requests requiring personal information shall be provided through photocopies. There will be no charge for the sharing of copies to individuals, agencies or organizations which require copies for the benefit of the client's rehabilitation program. Otherwise, photocopies are $ .25 per page.

A client may submit a written request to add, delete, or amend information contained in the case record. The Unit Manager/Facility Director shall make a decision whether to amend the record. If the record is to be amended, the Division shall:

A. Amend any portion of the record which is not accurate, relevant, timely, or complete by making appropriate notations on the record; OR
B. Insert corrective material into the file.

If the decision is made not to amend the record, the Division shall inform the client in writing of the decision, the reason for such decision, and the procedures for the client placing statements into the record.

1-3-2: Requests for Client Information

All requests for information shall be in writing. The consent for disclosure shall contain:

A. The name of the client;
B. The name or title of the person or organization to whom the disclosure is to be made;
C. The extent or nature of the information to be disclosed;
D. A statement that the consent is subject to revocation at any time;
E. The date on which the consent is signed; AND
F. The signature of the client.

When a requested record has been identified and is available, the Division shall notify the party requesting the information as to where and when the record is available for inspection or that copies will be available and will be sent by mail. The notification shall also advise the requesting party of any applicable fees.

If a requested record cannot be released or located from the information supplied or is known to have been destroyed or otherwise disposed of, the party requesting the information shall be so notified. A response denying a written request for a record shall be in writing and shall include:

A. The identity of the person responsible for the denial; AND
B. A reference to the specific law or regulations authorizing withholding of the record with a brief explanation of how the regulations or law applies to the information being withheld.

When confidential information is released or release is denied, the counselor releasing it or denying the release shall place an entry in the Case Notes stating:

A. The name of the person to whom it was given or by whom requested, if the request is denied;
B. The date the information was released;
C. The documents released or reviewed; AND
D. The reason for such release or denial.

Disability Determination Section

Regulations of the Social Security Disability Insurance Beneficiaries and Supplemental Security Income program authorize the disclosure of information about the claimant by the Disability Determination Section and the Social Security Administration. Likewise, the regulations authorize this Division to disclose client information to these parties for the purpose of disability determination, which includes the appeals process when claimants are denied benefits. During the application process for these benefits, the claimant must authorize the Disability Determination Section and the Social Security Administration to collect any medical records or other information about the disability from physicians, hospitals, agencies, or other organizations. This signed release by the client meets the requirements set forth in the Division policy, and authorizes the counselor, when requested by the Disability Determination Section or the Social Security Administration, to forward copies of medical records or other information about the client's disability for the purposes of disability determination. Counselors are authorized to release information to the Disability Determination Section upon written or oral request. If the request is oral, counselors should note in the Case Notes the date of the request, the information being requested, and the name of the individual making the request. Re-disclosing confidential information obtained from Disability Determination Section and from the Social Security Administration is permitted with client consent.

1-3-3: Release of Confidential Information *With* the Consent of the Client

When the client requests that information be released to another individual, Division or organization, the Division upon receiving the informed written consent of the client, shall release to such other individual, Division or organization for its program purposes only that information which may be released to the client, and

only to the extent that the other individual, Division or organization demonstrates that the information requested is necessary for its program. Information which is determined by the Division to be harmful to the client shall be released only when the other individual, agency, or organization assures the Division that the information will be used only for purposes for which it is being provided and will not be further released to the client. When a client requests release of confidential information to the client, parent, guardian, or representative, all confidential information contained in the client's file may be inspected and copied with the exceptions as noted below:

- On rare occasions, certain information obtained from another organization is restricted from further re-disclosure. Such information is generally so marked and the Division will honor such restrictions by directing the client to the original source. (Most agencies and organizations, including the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and the Social Security Administration, permit re-disclosure with client consent).

- Any information including medical or psychological information, which, in the judgment of the counselor may be harmful to the client, may not be released to the client. If the client is a minor, it may be released to the client's parent, guardian, representative, or to a physician or licensed psychologist. Some information is so sensitive and potentially harmful that the counselor shall seek consultation with the Assistant Director for Program Operations or the Section Chief of Program Policy, Planning, and Evaluation before responding to the request. When releasing such information, the Division shall caution the party receiving the information that it may be harmful to the client and; therefore, the receiving party is responsible for the use of the information.

1-3-4: Release of Confidential Information *Without* the Consent of the Client

An employee may, in the course of providing rehabilitation services, disclose confidential information without the consent of the client to other Division employees. The Division may authorize the release of confidential information to an organization, agency, or individual engaged in audit, evaluation, research, only for purposes directly connected with the administration of the program or for purposes which would significantly improve the quality of life for individuals with disabilities. Inquiries of this nature should be directed to the Section Chief of Program Policy, Planning, and Evaluation. Before participating in such activities, the Division will require assurance that:

A. The information will be used only for the purposes for which it is being provided;
B. The information will be released only to persons officially connected with

the audit, evaluation or research;

C. The information will not be released to the client;
D. The information will be managed in a manner to safeguard confidentiality; AND
E. The final product will not reveal any personal identifying information without the informed written consent of the client.

The Division may share confidential information on a need-to-know basis with its trainees, interns, and volunteers, who shall be bound by Division policy concerning confidentiality in the same manner as employees.

Confidential information must also be released without consent in the following situations:

A. In order to protect the client or others when the client poses a threat to his or her safety or the safety of others;
B. If required by Federal law;
C. In response to investigations in connection with law enforcement, fraud, or abuse; AND
D. In response to court order.

Periodically, the Division will receive requests for client information from attorneys in Workers' Compensation cases, who will not present consent for release, but will assert that Workers' Compensation information is not privileged under N. C. Law. G. S. 97-27 does state that information from physicians and surgeons who examine injured workers shall not be privileged. However, the Division must require client consent because Federal law and regulation *(34 CFR 36l.49)* must prevail in this situation.

1-3-5: Subpoenas

An employee who receives a subpoena shall contact the Chief of Policy or Section Chief of Program Policy, Planning, and Evaluation. A subpoena is either an order to appear and testify at trial or at a deposition or to produce documents (a subpoena duces tecum), at trial or a deposition. The subpoena itself does not obviate or overrule the confidentiality regulations dealing with client records and, therefore, client confidentiality may be invoked when questions are asked about confidential client information. This is applicable to either testimony at trial or production documents at trial or testimony at a deposition. In the case of the former, the judge would decide on the spot whether to order the testimony or production; and if an employee is so ordered, he or she would be required to testify or produce the documents. In the case of the latter, interposing client confidentiality would require the party to obtain a court order compelling the requested testimony.

Upon receiving a subpoena to appear and testify in court, the employee shall

attempt to secure written client consent by informing the client or the attorneys involved of the need for a signed release. The employee shall appear according to the terms of the subpoena. If no client consent has been given, the employee shall inform the court of the requirements of the law and regulations concerning confidentiality and shall testify only upon judicial order. A subpoena to produce documents (subpoena duces tecum) at a deposition raises a different procedural problem. Again, client consent should be pursued, with the attorneys involved being immediately contacted and informed of the need for a signed client release. However, unless an objection to inspection is made in apt time, Rule 45(d) (l) of both the Federal and State Rules of Civil Procedure requires that the documents be produced and permitted to be inspected and copied. Upon receipt of a subpoena for the production of client information at a deposition, and absent consent of the client, written objection to the production of documents should be served on the attorney or such other person designated in the subpoena. The written objection to production must be served ". . . within l0 days of the service (of the subpoena on the employee, either by personal service or by registered or certified mail) or on or before the time specified in the subpoena for compliance if such time is less than l0 days after service . . ." The written objection to production of documents should read as follows: "Pursuant to Rule 45(d) (l) of the North Carolina Rules of Civil Procedure (Federal Rules of Civil Procedure should be substituted if the action is filed in Federal court), the Division of Vocational Rehabilitation Services, North Carolina Department of Health and Human Services, and the undersigned employee thereof, object to the inspection or copying of the documents designated in the subpoena directed thereto on the grounds that the documents are confidential pursuant to 34 CFR 36l.38 (e)(3)." Upon service of the written objection, the employee is relieved of the duty to produce the documents. Thereafter, the burden is on the party issuing the subpoena to obtain a court order to compel production, but only after notice is given to the deponent (employee). The order may be obtained at any time before or during the taking of the disposition. In the vast majority of cases, attorneys are cooperative and generally obtain the proper consent and thereby obviate the need for a judicial order.

On rare occasions, certain information which the Division received from another source may be restricted from further disclosure by the original source. That information is generally so marked when the Division receives it and the Division should honor the restrictions on re-disclosing. The Division should respond to subpoenas for such information by directing the person issuing the subpoena to the original source. If the subpoena requires a court appearance, the employee shall follow the order of the court after drawing the court's attention to the Federal regulations concerning confidentiality.

The employee may testify without client consent about general information concerning the Division, such as services available and eligibility criteria.

[34 CFR 36l.38]

Section 1-4: Client Assistance Program (CAP)

The CAP, as mandated by 1984 Amendments to the Rehabilitation Act of 1973, was developed to assist individuals with disabilities with resolving concerns related to accessing rehabilitation services. Services available through CAP include:

- Assistance to consumers in resolving concerns related to the application for and the provision of or denial of services.
- Explanation to consumers of rehabilitation policies and procedures.
- Assistance to consumers in requesting an Administrative Review and/or an Appeals Hearing.
- Provision of legal consultation if required in those cases which reach the Appeals Hearing level of the appeal process (in these cases, CAP is empowered to contract with private attorneys for this service).
- Provision of information/referral services to individuals with disabilities seeking information about independent living, vocational rehabilitation, and other rehabilitation programs.

Each applicant for services must receive *The Agreement of Understanding with the North Carolina Division of Vocational Rehabilitation Services and Applicants for Services* and a CAP brochure. When working with an individual with known or suspected limited reading skills, this information must be thoroughly reviewed to assure full understanding of the CAP.

CAP places a strong emphasis on early intervention and on the use of mediation and negotiation strategies to resolve the consumer's concern at the local or regional level whenever possible.

The CAP Director must be notified immediately upon receipt of a consumer request for an Administrative Review and/or an Appeals Hearing. The CAP director is also involved in the review and development of Division policy and procedures.

[34 CFR 370]

Section 1-5: Client (and Applicant) Appeals of Division Decisions Including Administrative Reviews and Mediation

The Division provides a procedure through which any individual receiving or applying for services from the Division who is dissatisfied with any determinations made by the Division concerning the provision of services may request a timely review of those determinations. This policy applies to the Independent Living Program as well as to the Vocational Rehabilitation Program. The applicant/client has the right to an appeals hearing before an impartial hearing officer within 45 days of the Division's receipt of a written request for an appeals hearing. The applicant/client also has the option of seeking resolution of the issue through mediation and/or an administrative review prior to an appeals hearing, but these procedures cannot be required. Division staff will assist applicant/clients with their written request for administrative reviews, mediation, or appeals hearings. Assistance with the resolution of their problems is also available through the Client Assistance Program (CAP).

At the time of application for services, when the Individual Plan for Independent Living (IPIL) is developed, and when services are being reduced, suspended or terminated, all applicant/clients shall be given written information informing them:

A. That they have a right to an appeals hearing when they are dissatisfied with any determination(s) made by the Division that affects the provision of services;
B. That they have the option of seeking resolution of the issue through an administrative review prior to an appeals hearing;
C. That mediation may be available to resolve their issues if the Division agrees to it;
D. That the Rehabilitation Counselor, Appeals Coordinator, or other designated staff of the Division will assist them in preparation of the written request for an administrative review mediation and/or appeals hearing.
E. Of the name and address of the appropriate Regional Director to whom the request shall be submitted; AND
F. That they may receive assistance with the resolution of their problems through the Client Assistance Program (CAP).

The counselor shall review this information with the applicant/client in a manner that is understandable to the individual. The applicant/client's signature on *Form ILRP-1001* for IL applicants confirms that this information was provided and explained. All applicants shall be given a copy of this information.

Request for Administrative Review, Mediation and Appeals Hearing

When any applicant for or an individual receiving services wishes to request an administrative review mediation and an appeals hearing or only an appeals hearing the applicant/client shall submit a written request to

the appropriate Regional Director. The request shall indicate if the applicant/client is requesting an administrative review, mediation, and an appeals hearing to be scheduled concurrently; an administrative review and an appeals hearing to be scheduled concurrently; or only an appeals hearing. The request shall contain the following information:

A. The name, address and telephone number of the applicant/client; AND
B. A concise statement of the determination(s) made by the rehabilitation staff for which an administrative review, mediation and/or appeals hearing are being requested and the manner in which the person's rights, duties or privileges have been affected by the determination(s).

The Division shall not suspend, reduce or terminate services being provided to a client under an IPIL pending final resolution of the issue through mediation, an administrative review or an appeals hearing unless the applicant/client or the applicant/client's representative so requests, or the Division has evidence that the services have been obtained through misrepresentation, fraud, collusion, or criminal conduct on the part of the applicant/client.

Response to Request

A. Upon receipt of a request for an appeals hearing the Regional Director shall immediately forward the original request to the Section Chief of Program Policy, Planning, and Evaluation who will arrange for the Appeals Coordinator to provide the applicant/client with information about the possibility of mediation (if mediation has been requested) and appoint a hearing officer to conduct the appeals hearing;
B. If the applicant/client has requested an administrative review in addition to the appeals hearing, the Regional Director shall:

    1. Make a decision to conduct the administrative review or appoint a designee to conduct the administrative review who:
        (a) Has had no previous involvement in the issues currently in controversy;
        (b) Can conduct the administrative review in an unbiased way; AND
        (c) Has a broad working knowledge of the Division’s policy, rules, Federal regulations governing the program, and the State Plan for Vocational Rehabilitation Services or the State Plan for Independent Living Services (as appropriate).

AND

2. Proceed with, or direct the designee to proceed with an administrative review according to the provisions of this policy;

C. The Regional Director shall send the applicant/client written acknowledgment of receipt of the request and inform the applicant/client that additional information will be sent regarding the possibility of mediation (if mediation has been requested) and the administrative review and/or appeals hearing (see SCHEDULING, NOTICE OF, AND CONDUCTING ADMINISTRATIVE REVIEW below). If this information is available, it can be included in the letter of acknowledgment;

AND

D. The Regional Director shall provide the Client Assistance Program (CAP), if assisting the applicant/client with the case, and the Appeals Coordinator with a copy of the request and the response to the request.

Scheduling, Notice Of, and Conducting Administrative Review

If an administrative review is to be conducted, the Regional Director or designee shall:

1. Set a date, time, and place for the administrative review;
2. Send written notification by certified mail to the applicant or client and the parent(s), guardian, or representative, as appropriate, of the date, time, and place for the administrative review at least five days prior to the administrative review
3. Advise the applicant or client in the written notice:

   (a) That additional information will be sent regarding mediation if mediation has been requested;
   (b) That arrangements will be made for a hearing officer to conduct an appeals hearing if the matter is not resolved in the administrative review or mediation; AND
   (c) That the applicant or client will also receive a written notice from the hearing officer regarding the formal appeals hearing which will be held after the administrative reviewand mediation (if mediation is scheduled);

AND

4. Notify the Director of the Client Assistance Program (CAP) and other individuals to be involved in the administrative review of the

request and the date, time and place for the administrative review. This notification may be by phone or in writing.

Prior to the administrative review the Regional Director or designee shall review all previous decisions and casework related to the applicant or client and seek whatever consultation, explanation, documentation, or other information that is deemed necessary, utilizing the Division's CAP Director as appropriate.

The administrative review must be conducted within 15 days of receipt of the original request. Within five working days of the administrative review the Regional Director or designee shall make a decision and notify the applicant or client and others using the following procedures:

1. Compiling a written report of the administrative review outlining the purposes of the administrative review the participants, the decision that was reached, and the rationale for the decision;
2. Sending the written report containing the decision to the applicant or client by certified mail with return receipt requested, with a copy being placed in the applicant/client's official case record, and copies being forwarded to the Appeals Coordinator and the CAP Director (if CAP is involved), and
3. Providing instructions to the applicant or client of steps that may be taken in response to the decision and the deadline for the responses.

A form indicating agreement with the decision and requesting that the hearing (and mediation if scheduled) be canceled shall be included for the applicant/client's signature if the applicant/client agrees with the decision. If the applicant/client is satisfied with the decision resulting from the administrative review, the applicant/client shall sign the form and return it to the Regional Director within five days of receipt of the decision. The Regional Director shall inform the Appeals Coordinator of the request to cancel the hearing immediately and forward the form to both the Appeals Coordinator and the Chief of Policy for submission to the hearing officer. If the Regional Director does not hear from the applicant or client within the five days indicated, it is recommended that the Regional Director contact the applicant or client to verify that the person does understand the procedures and does wish to proceed with the formal appeals hearing.

Administrative Review by Section Chief of Program, Policy, Planning and Evaluation

In situations where the issue currently in dispute involves action taken by the central office of the Division, the Section Chief for Program Policy, Planning, and Evaluation or designee shall be responsible for the duties related to the administrative reviews that are prescribed for the Regional

Director in this policy.

Appointment of Hearing Officer

Upon receipt of the applicant/client's request for an appeals hearing from the Regional Director, the Section Chief for Program Policy, Planning, and Evaluation shall contact the Appeals Coordinator for the appointment of a qualified mediator (if mediation has been agreed upon by the applicant/ client and the Division) and an impartial hearing officer. The hearing officer will be selected on a random basis without replacement from the pool of qualified hearing officers who meet the requirements of the Rehabilitation Act and have been approved by the Division and the State Rehabilitation Council. This is done concurrently with the scheduling of an administrative review (if one has been requested) in order to meet the 45-day deadline required by the Rehabilitation Act.

[10 NCAC 20B .0206]

Mediation

The Appeals Coordinator will inform the applicant/client in writing that the issue may be resolved through mediation prior to the appeals hearing (and usually after the administrative review, if one is scheduled) if both the applicant/client and the Division agree to mediation. The Division Director will make the decision regarding the Division's participation in mediation.

If both parties agree to mediation, the Coordinator will make arrangements for an impartial mediator from the Division's list of qualified mediators to conduct the mediation. (A qualified mediator must be an individual who has been Certified by the N.C. Dispute Resolution Commission or approved by the Mediation Network of North Carolina. The mediator also must be knowledgeable about Vocational Rehabilitation law and regulations.)

The Coordinator will make arrangements for the mediation to be conducted in a location that is convenient to both parties. The mediation will be scheduled so that the appeals hearing can be conducted within the required 45-day time frame if possible. If this schedule is not possible, the appeals hearing may be delayed if both parties sign a written agreement for a specific extension of time. The Coordinator will send both parties written confirmation of the mediation: the time and place, the mediator's name, and any instructions relating to the process.

Both parties will sign a statement prior to the mediation agreeing to keep all discussions occurring during the mediation confidential. If an agreement is reached during the mediation, it must be in writing and signed by both parties. The written agreement may be submitted as documentation during the appeals hearing and any subsequent court

actions. However, discussions, proposed settlements, and other information not reflected in the mediation agreement must be kept confidential, but evidence that is otherwise discoverable shall not be inadmissible merely because it is presented or discussed during mediation.

The Division will pay for the expenses involved in the mediation process.

Scheduling and Notice of Formal Appeals Hearing

The hearing officer shall schedule the formal appeals hearing to be held within 45 days of the original request by the applicant/client. The hearing officer shall provide the applicant/client and the Division written notice of the date, time and place of the hearing and the issue(s) to be considered at least 10 days prior to the hearing. A copy of the notice shall also be sent to CAP if CAP is assisting the applicant/client. The notice shall state:

A. The procedures to be followed in the hearing;
B. The particular sections of the statutes, Federal regulations, State rules, and State Plan involved;
C. The rights of the applicant or client to present additional evidence, information**,** and witnesses to the hearing officer, to be represented by counsel or other appropriate advocate, and to examine all witnesses and other relevant sources of information and evidence;
D. That the hearing officer shall extend the time for the hearing if the parties jointly agree to a specific extension of time and submit a written statement to that effect to the hearing officer; AND
E. That the hearing may be canceled if the matter is resolved in an administrative review or through other negotiations including mediation

Notice shall be given personally or by certified mail. If given by certified mail, the date of notification shall be the delivery date appearing on the return receipt. If the hearing officer does not receive a written request from the applicant/client that the hearing be canceled, the hearing shall be conducted as scheduled unless negotiations produce a settlement that is satisfactory to both parties prior to the hearing. If the hearing is canceled, the hearing officer shall send the applicant/client and the Division written notice of the cancellation in the same manner as required for notice of the hearing. A copy of the notice of cancellation shall be sent to CAP if it is involved.

Procedures Governing Hearing

The appeals hearing shall be conducted according to the provisions of Federal Regulation 34 C.F.R. 361.57(b)(l)-(4) and (12) and (c) and

according to the provisions of Division rules in 10A NCAC 89B .0212 through .0222 and .0225.

Hearing Officer's Decision

Within 30 days of the completion of the hearing, the hearing officer shall make a decision based on the provisions of the approved State Plan and the Rehabilitation Act (this would include Federal and State Regulations and Division policy that are consistent with the State Plan and the Rehabilitation Act) and provide the applicant/client or, if appropriate, the applicant/client's parent, guardian, or other representative, and to the Division Director, with a full written report of the findings and grounds for the decision. The decision shall be given to the applicant/client and the Division Director personally or by certified mail. If given by certified mail, the delivery date appearing on the return receipt shall be delivery date of record.

The impartial hearing officer's decision is the final decision unless a review by the Secretary of DHHS is requested by either party or one of the parties brings a civil action for review by the courts of the decision.

Review and Final Decision by Secretary of DHHS or Designee

Either party (the applicant/client or the Division Director) may request a review of the hearing officer's decision by the Secretary of the Department of Health and Human Services within 20 days of the receipt of the decision.

The Secretary may delegate the responsibility for reviewing the hearing officer's decision to another employee of the Department but shall not delegate the responsibility to any officer or employee of the Division.

The reviewing official shall send written notification of the review to both parties and allow the submission of additional evidence as required by the Rehabilitation Act. The written notice must be given personally or by certified mail. If given by certified mail, the delivery date appearing on the return receipt shall be the delivery date of record.

The reviewing official's review shall be based on the following standards of review:

- Decisions that are neither arbitrary, capricious, an abuse of discretion, or otherwise unreasonable.
- Decision supported by substantial evidence and consistent with facts and applicable Federal and State policy.
- Decisions reflecting appropriate and adequate interpretation to such factors as:
  (a) The Statute and Regulations as they apply to specific issue(s) in question;

(b) The State Plan as it applies to the specific issue(s) in question;
(c) Division rules as they apply to the specific issue(s) in question;
(d) Key portions of conflicting testimony;
(e) Division options in the delivery of services where such options are permissible under the Federal Statute; AND
(f) Restrictions in the Federal Statute with regard to such supportive services as maintenance and transportation.

The reviewing official shall not overturn or modify a decision, or part of a decision, of an impartial hearing officer that supports the position of the applicant/client unless the reviewing official concludes, based on clear and convincing evidence, that the decision of the independent hearing officer is clearly erroneous on the basis of being contrary to the approved State Plan or Federal or State Law, including rules and regulations and Division policy that are consistent with Federal Law.

Within 30 days of the Secretary's receipt of the request to review the impartial hearing officer's decision, the reviewing official shall make a final decision and provide a full report in writing of the decision, including the findings and grounds for the final decision, to the applicant or client; or, if appropriate, the applicant/client's parent, guardian, or other representative; and the Division Director. The final decision shall be given to both parties personally or by certified mail. If given by certified mail, the delivery date appearing on the return receipt shall be the delivery date of record.

The Division Director shall forward a copy of the final decision to the Section Chief for Program Policy, Planning, and Evaluation, the CAP Director, the Regional Director, and the applicant's or client's representative, as appropriate. A copy shall also be included in the applicant/client's official case record.

Copies of all final decisions must also be submitted to the State Rehabilitation Council but in a manner that ensures that all identifying information of applicant/clients is kept confidential.

Implementation of Decision

The final decision issued by the impartial hearing officer or the reviewing official shall be implemented regardless of whether a party has filed a civil action in the case. That implementation will stand pending a final decision in any civil action.

Extensions of Time

Reasonable time extensions may be granted for the various steps in these procedures for good cause shown at the request of a party or at the

request of both parties except for:

- The time for continuation of services during the administrative review, mediation, and the appeals hearing unless the applicant/client requests that services be stopped or unless there is evidence that services have been obtained through misrepresentation, fraud, collusion, or criminal misconduct on the part of the applicant/client
- The 45-day time for conducting the appeals hearing which may be extended only when the Appeals Coordinator or the hearing officer extends the hearing for a specific period of time upon a written request of both parties
- The 10-day time for issuance of the written notice of the formal appeals hearing
- The 20-day time frame for requesting a review of the hearing officer's decision
- The 30-day time for the reviewing official's issuance of a final decision.

When an extension of time is being granted by the person conducting the administrative review or meditation or by the hearing officer, consideration shall be given to the effect of the extension on deadlines for other steps in the administrative review and appeals process.

Record

The official records of appeals hearings shall be maintained in the central office of the Division by the Section Chief for Program Policy, Planning, and Evaluation.

Any person wishing to examine a hearing record shall submit a written request to the Section Chief for Program Policy, Planning, and Evaluation in sufficient time to allow the record to be prepared for inspection, including the removal of confidential material.

Transcripts

Any person desiring a transcript of all or part of an appeals hearing shall contact the office of the Section Chief for Program Policy, Planning, and Evaluation. A fee to cover the cost of preparing the transcript shall be charged, and the party may be required to pay the fee in advance of receipt of the transcript. The transcript may be edited to remove confidential material.

Civil Action

Any party (the applicant/client or the Division) aggrieved by a final decision may bring a civil action for review of such decision by a State Court of competent jurisdiction or in a United States district court of competent jurisdiction.

The party seeking judicial review in a State court must file a petition in Superior Court of Wake County or in the superior court of the county where the person resides within 30 days after the person is served with a written copy of the decision. Court review in a United States district court will be governed by the Federal laws applicable to such situations.

[CFR. 361.57; 10A NCAC 89B Section. 0200; 1998 Amendments to the Rehabilitation Act, Section 7(16) and Section 102(c)

Section 1-6: Social Security Work Incentives

Individuals receiving SSI and/or SSDI are offered a variety of work incentives and programs which may have little or no impact on their benefits. These incentives are explained in SSA publication No. 64-030 entitled A Summary Guide to Social Security and Supplemental Security Income Work Incentives For People With Disabilities.

The Social Security Act no longer provides for suspension of benefits to those SSDI beneficiaries and SSI recipients who refuse, without "good cause," to accept Vocational Rehabilitation (VR) services.

Section 1-7: Implications of Section 504 and Americans with Disabilities Act (ADA)

It is the policy of this Division that full compliance with the requirements set forth under Section 504 of the Rehabilitation Act of 1973, as amended (PL 93-112) will be maintained in all areas of programming, and services provision. The Division will implement all necessary procedures set forth in 45 CFR, Part 84, to assure full compliance with the requirements by the required dates. All policies and procedures relative to provision of services, employment, and programming within the Division will be carried out with due consideration to these requirements. The Program Policy, Planning, and Evaluation Section should be consulted on compliance issues related to client services. The Director of Human Resources is designated as the responsible party for assuring compliance with employment requirements under this Section.

[Section 504, Rehabilitation Act of 1973, as Amended; 45 CFR 84; 29 USC 706]

Section 1-8: Nondiscrimination

All policies are applied without regard to sex, race, age, creed, color, national origin or type of disability of the individual applying for service.

[34 CFR 364.41]

1-8-1: Disability Group

No individual will be found ineligible for services or be restricted from Division services on the basis of the type of disability.

1-8-2: Age

There is no upper or lower age limit which will, in and of itself, result in a finding of ineligibility for any individual who otherwise meets the basic eligibility criteria. It is clear that the Rehabilitation Act is directed to the rehabilitation of individuals for employment or independent living. While it is clear that some services may be initiated prior to the current employable age (in North Carolina) of sixteen years old, these individuals are not likely to be employable or be able to live independently. An individualized rehabilitation program may not be appropriate until a later age.

1-8-3: Residence

No state residency requirement can be imposed which excludes from services any individual who is otherwise eligible unless the individual comes to North Carolina for the sole purpose of becoming a client of the Division. However, counselors should not assess or provide services until confirmation that the individual is not being served or will not be served by the resident State vocational rehabilitation program is determined.

[34 CFR 364.41]

Section 1-9: Identification and Verification

1-9-1: Social Security Numbers

A social security number is required on each applicant for or client of rehabilitation services prior to closing client records in case status codes 58, 76, 78 or 80. Should an applicant/client lose his/her number or have never applied for a social security number, counselors have the responsibility for assisting the applicant/client in completing the appropriate request for either a duplicate card or an original from the Social Security Administration. The disability benefits verification process used at application for services can be used to verify the existence of an SSN when an applicant cannot locate or cannot remember his/her SSN as long as the individual can provide the name, date of birth, race, ethnicity, and primary language associated with the SSN. Services should not be delayed pending issuance and/or receipt of the social security number unless the counselor has information contrary to the requirements noted in 1-9-2.

1-9-2: Citizenship and Employment Eligibility

The Immigration Reform and Control Act of 1986 (IRCA) was passed to control unauthorized immigration to the United States. The Immigration Reform and Control Act made all U.S. employers responsible to verify the employment eligibility and identity of all employees hired to work in the United States after November 6, 1986. To implement the law, employers are required to complete Employment Eligibility Verification forms (Form I-9) for all employees, including U.S. citizens.

Citizens of the U.S. include persons born in Puerto Rico, Guam, the U.S. Virgin Islands, and the Northern Mariana Islands. Nationals of the U.S. include persons born in American Samoa, including Swains Island.

Appropriate documentation to establish identity is required prior to VR/IL eligibility and the delivery of services. Documents which are acceptable are listed on Immigration and Naturalization Service Form I-9. The current version of this form may be found at:

http://uscis.gov

Visual verification of allowable documents is required in all cases in which a valid SSN is not produced. Visual examples of the allowable documentation required for employment verification may be referenced in the section on "acceptable documents for verifying employment verification" of the *Handbook for Employers: Instructions for completing Form I-9* found at:

http://www.uscis.gov/files/form/m-274.pdf

Section 1-10: Repossession, Storage, and Disposal of Equipment

The counselor should repossess equipment purchased for clients when the equipment is not being used for the intended purpose and it is unlikely that the equipment will be used for such in the foreseeable future or for reasons as specified on the DVR-1015. When equipment costing more than $500 is repossessed, the Counselor should consult with the Purchasing Manager on disposal of the equipment and arrangements for storage. In some cases, repossessed equipment may be of use to another client. The equipment should be safely stored until reassignment is made. In other situations, equipment may not be feasibly transferred to another client because of the customization or general condition of the equipment. The Purchasing Manager can advise on the disposition of equipment in such cases. If necessary, the Unit Manager may designate staff to pick up and safely transport repossessed equipment to another location. The Unit Manager should arrange for the transportation of equipment items that staff cannot safely move by contacting the Assistant Regional Director.

Repossessed equipment that might be of use to another client may be stored

locally or in a regional storage area or in the purchasing section of the state office. If such storage space is not available, the Purchasing Manager and/or Assistant Regional Director should be consulted regarding other options for storage of the equipment.

Section 1-11: Case Service Authorizations

Case service authorizations must be issued prior to or on the effective date of the service being authorized. While it is allowable to issue a verbal authorization in times of emergency situations, written authorization must be issued within three days to cover the service. The intent is to assure the vendor and the clients are aware of the service(s) being authorized. Services not authorized should not be purchased. Any retroactive authorization exceeding seven days must be approved by the Unit Manager except for required ancillary services associated with surgical procedures that are routinely authorized.

Section 1-12: Invoice Processing

In order to meet Federal requirements regarding authorization for services, rates of payments, and determination of comparable benefits, the Division requires the submission of an invoice for any service provided to a client that is consistent with the corresponding authorization for services. Invoices must be submitted on forms specified in this policy and found on CATS along with required supportive information. Other required information includes client name, IL#, client ID, R2#, inclusive dates of service, complete description of service, vendor name, vendor address, caseload code, counselor code, and the counselor's signature indicating review and approval of the invoice.

1-12-1: Vendor Signatures

***Purchase Orders*:** Vendor signatures are not required when a purchase order has been issued by the Purchasing Unit. Neither a case service invoice nor an authorization is sent to the vendor in this case.

***Signatures on File (Medical Vendors only)*:** Vendor signatures are not required for Medical Vendors who have completed a *DVR-0108, Certificate of Signature on File*. However, all medical invoices processed without a signature on file must be signed by the provider.

***Attached documentation*:** Vendor signatures are not required if there is attached documentation that verifies the invoiced amount, service equipment, training etc. Examples of documentation include but are not limited to:

- Packing Slips and receipts
- Cash register or other sales receipts
- Invoice on letterhead with itemized list
- Invoices for copying Medical Records

- Computer generated invoices that identify the name of the company, date and itemized list of purchases

***Case Service Invoice (DVR-1013)*:** Signatures are required on the Division's case service form when it is the only submitted documentation and none of the above attached documentation is attached. Examples include but are not limited to:

- Invoices for the client is the vendor
- Interpreters, tutors and private transportation vendors who are not affiliated with a company
- Transportation vendors that are not public or for profit companies with a separate invoice

Invoices are to be submitted on one of the following required invoice forms:

A. Case Service Invoice *(DVR-1013)*: This is the general purpose invoice used by the Division for such services as tuition, fees, books, supplies, on-the-job training, supported employment, equipment, maintenance, transportation, imprest cash, personal care assistance, residence modifications and others.
B. Medical Invoice (*Form DVR-0107*): Health Insurance Claim Form, 1500 may be substituted for all medical HCFA and hospital services, speech, hearing, orthotic, anesthesia, radiological, and others.
C. Dental Invoice (*Form DVR-0126*): Used for dental services.
D. Eyeglass Invoice (*Form DVR-0199*): Used for eyeglass billing.
E. Pharmacy Invoice (*Form DVR-0101*): Used for over-the-counter and prescription medications and others.

1-12-2: Additional Information Required on Invoices

Case Service Invoices (General Invoices): Listed below are the types of services normally billed on the Case Service Invoice (*Form DVR-1013*) along with additional information needed and edits required prior to processing. CATEGORY, item 9, must be completed to properly identify the reason for providing the service. The four categories are diagnostic, treatment, training, and placement. The category must be the same as item 19 on the case service authorization.

Attendant Care/Personal Assistance Service Invoices: Must be accompanied by time sheets for invoiced period.

Housing Placement and Assistance Invoices*:* Included in this category are home furnishings and the invoice must be accompanied by an itemized list of purchases.

Housing and Transportation Modification Invoices*:* Should have itemized bills attached and bills for payment must also have the engineer's

signature indicating inspection and approval.
***Maintenance Invoices**:* Must indicate which services are being sponsored (meals, room, or both). Meals should not exceed actual cost or State per diem rates, whichever is less. Invoices for room and board must not exceed the allowable rates as specified in Volume V. Invoices including dormitory fees billed by the college or university, cannot be paid more than two weeks prior to beginning date of service and cannot exceed thirty days unless prior approval is given by the Chief of Policy.

Social and Recreational Service Invoices: Should include itemized list of items purchased.

***Technological Aids and Device Invoices**:* For prosthesis and orthotics must not exceed allowable rates as specified in Volume V. Invoices for environmental control units, augmentative communication devices, etc., must be accompanied by an itemized list of items purchased.

***Transportation Invoices**:* Must list number of miles, number of trips and rate per mile. Invoices for public conveyance must list the number of trips unless the invoice is for a monthly bus pass or a book of bus tickets. If invoices are completed in this manner, an attached receipt is unnecessary. Invoices cannot be paid more than two weeks prior to the beginning date of the service and should not exceed thirty days.

***Other Services**:* Allow services not listed elsewhere on the case service invoice form. They must be itemized either on the case service invoice or an attachment. The following are examples:

- **Equipment Invoices** must be itemized and identified as either placement or training equipment for CS coding purposes. Equipment used for training purposes should not be invoiced as a supply line item. A note of justification should be submitted indicating the equipment is required by the employer or the instructor.
- **Personal Needs Invoices** cannot exceed the allowable rate, cannot be paid more than two weeks prior to beginning date of service and should not extend beyond thirty days.
- **Imprest Cash Fund Invoices** require copies of the *Imprest Cash Receipt* (*Form DVR-2048*) along with other information relevant to the service being provided. For example, imprest checks which are to be used for maintenance services should provide the same information required for other maintenance invoices. The invoice must be signed by the client, counselor and Unit Manager or designee. Receipts indicating that funds were used for the purposes intended should be forwarded with the invoice whenever possible.

Dental Invoices: Require the same information as medical claims, but the procedure codes are paid according to American Dental Association (ADA) codes. Preventive procedures, as noted in Volume V of the Reference Library, should not be authorized: if invoiced without adequate justification, these procedures will not be considered for payment.

Eyeglass Invoices: Eyeglasses Ordering/Claim Forms require much the same information as a medical claim but the amounts paid are according to rates established by a contract entered into between DHR and a selected vendor. The optometrist or ophthalmologist should complete and sign this form. Detailed instructions for the purchase and payment of eyeglasses are on the reverse side of each page of the form DVR-0199.

Hospital Invoices: For inpatient and outpatient services shall be submitted on the hospital's billing form and are graded at the Medicaid rate according to the rate effective on the date of discharge. A copy of the authorization must be attached to the invoice since dates of service are verified against the authorization. If the invoice has a beginning date prior to the effective date of the authorization, the invoice will be returned to the counselor for verification/correction. Invoices extending three days beyond the number of days authorized will be returned to the counselor for review and explanation. Hospitals can bill the client for any days not covered by the Division of Vocational Rehabilitation, but cannot bill the client for additional monies for days and services authorized by the DVR. Hospitals also cannot bill the client for remaining balances from payments made on services covered. Although inpatient and outpatient services can be authorized as separate line items on the same R2, inpatient services cannot be invoiced against an outpatient authorized line item. Physician services being billed by the hospital must be billed on the physician's invoice with a complete description of the service. Reports will be requested for clarification purposes. Payments for physician services cannot be made unless these services are specified on the authorization. For example, physician charges cannot be paid from an outpatient service line item on the authorization. These charges must be specified as a separate line item on the authorization.

Medical Invoices: At this time, only a Current Procedural Terminology (CPT) code is required to determine appropriate payment. If a code is not allowed or there is no listed rate, a report may be requested for grading purposes. Additional supporting information may sometimes be requested to confirm or assure proper payment. Preventive procedures will be removed from the invoice unless appropriate justification is received. Counselors and/or managers must keep medical service providers current on the Division's payment policies in order to help prevent misunderstandings.

Pharmacy Invoices: The Division changed its billing procedure for pharmacies,

effective 03/15/06, to conform to the standard form and process already utilized by NC Department of Public Health. Invoices must have the prescription number, the brand or generic name, the National Drug Code (NDC) number, strength, the concentration of drug per unit, the quantity of drug dispensed (e.g., number of tabs, caps ml, cc. oz), the date the prescription order was actually filled and amount billed for each drug. The prescription drug dispensing fee will be based on brand (b) or generic (g) which are required fields on the invoice form. The pharmacy invoice form is on CATS. Drug bills should be submitted to Case Service Accounting on a monthly basis to assure dispensing fees are paid only once per month per drug purchased. Dispensing fees are established by Medicaid and will not be paid unless listed separately on the invoice. Over-the-counter drugs are paid at over-the-counter prices with no dispensing fee allowed even if a prescription is written. Generic rates will be paid unless the physician writes "Dispense as Written" on the prescription order. This is a Medicaid rule. If a physician simply signs under or checks an identified heading, marking a specific block, or any other method, it will not be allowed by Medicaid policy nor VR policy and the generic equivalent fee will be paid. Overpays must be approved as stated earlier in this policy.

Prosthetic and Orthotic Invoices: Should be itemized with a complete description of the service provided and coded according to fee schedules found in Volume V. Fees for items not found in the fee schedule should receive prior approval as specified in those policies. *Invoices for services must include the client's date of birth.*

Psychological Services Invoices: Must indicate the assessment level as specified in Volume V. Psychotherapy invoices must include the number of sessions and the length of each session. Neuropsychological invoices must reflect the amount of time and be within the limits stated in Volume V. All invoices submitted by psychologists are reviewed to assure the providers are on the Approved Panel of Psychologists and to determine if they are listed as a dual employment provider. If appropriate, a CP-30 Dual Employment form must be completed, signed and attached to the invoice. The authorizing counselor signs the form as the Division representative.

Speech Therapy Invoices: Must include length of each session and number of sessions.

1-12-3: Comparable Benefits

When comparable benefits are listed on the authorization form, they must be clearly addressed on the invoice. Because of the variety of invoice forms received, there is no single area for comparable benefits to be noted. For example, if medical insurance is listed on the authorization as a comparable benefit, the counselor must indicate either the amount of the payment and

specify the procedure(s) for which the payment is to be applied towards, or indicate denial of benefit. The insurance denial letter or payment stub must be forwarded with the invoice. If a legal settlement is pending, the counselor shall review the financial situation with the attorney and advise the state office of the current status of the legal action when submitting the invoice for payment. An Assignment of Reimbursement should be attached to the invoice, when appropriate, in order to expedite the payment process. If Medicare is the comparable benefit, a copy of the Explanation of Benefit (EOB) is required prior to payment. Division funds cannot be used to complement or supplement a comparable benefit that pays at the Medicaid rate. If a comparable benefit pays more than the allowable state established rate, the Division is unable to contribute any payment towards the cost of the service. Invoices with Medicaid as the comparable benefit should not be forwarded for processing until Medicaid status is ascertained.

1-12-4: Overpayments

Any overpays must be approved by the counselor who issued the authorization. Unit Manager approval is required if the overpayment exceeds $100.00.

1-12-5: Prior Approval of Unusual Charges

Any service requiring prior approval is reviewed to assure approval is in place. Any service which appears excessive, not normally provided, non-routine or out-of-the-ordinary must be accompanied by a note of justification for review and approval purposes.

1-12-6: Duplicate Invoices

Duplicate invoices may become necessary if any invoice has not been paid in a reasonable period of time. A duplicate invoice must be submitted to Case Service Accounting with written notification requesting review and indicating the date the original invoice was submitted for payment. There is a two-week "hold time" prior to processing invoices to help prevent duplicate payment.

1-12-7: Request for Review

Request for review of the amount of payment for a service should be submitted to the supervisor of Case Service Accounting. This request should include the IL#, case service authorization number and any reports or justification that can be provided to help in the review for possible additional payment.

1-12-8: Weekly Check-Write

Checks are written weekly on Monday night. Checks issued to vendors are computer-generated by the State Computer Center. Final edits are conducted

electronically between the Case Service Authorization and the Case Service Invoice information while the checks are being printed. An error listing is developed which is composed of all invoices that differ from the supporting authorization. All checks are then manually edited against the invoice(s) and if not in agreement, the check is "pulled" for review and special handling. For example, if an established vendor has a change of address and the address on the invoice is different from the address on the authorization this difference must be corrected before the check can be released to the vendor. If a careful review is made comparing the invoice to the authorization prior to submission of the invoice to Case Service Accounting, this will help assure all information is in agreement and the proper vendor is paid for services in a timely manner.

[34 CFR 361.50; 361.53]

Section 1-13: VR/IL Concurrent Records of Service

The 1992 Amendments to the 1973 Rehabilitation Act strongly emphasize coordination and collaboration between the Vocational Rehabilitation Program and the Independent Living Rehabilitation Program in order to assure that clients with significant disabilities are able to access those services necessary to complete their rehabilitation program. Coordination of rehabilitation planning between the Vocational Rehabilitation (VR) Program and the Independent Living Rehabilitation (IL) Program is essential if the client is to achieve a successful vocational outcome. In order to enhance coordinated planning and service provision, statewide budget code RCC 1281 has been developed to promote continued involvement by the IL counselor and the VR counselor throughout the rehabilitation process. Case service authorizations may be issued by the vocational rehabilitation counselor from RCC 1281 during the assessment for determining eligibility and vocational rehabilitation needs as well as purchasing IL related services once an applicant has been determined eligible for VR services under the following conditions:

A. Such services are required for vocational rehabilitation purposes; AND
B. Such services are provided in a collaborative effort with the IL program.

In order to use this budget, it is required that joint planning occur early in the rehabilitation process or as soon as it is determined that the client must access both programs in order to have a successful employment outcome. The VR counselor may also elect to sponsor services under a concurrent record of service out of other case service funds. VR policy and maximum limits prevail whenever RCC 1281 or other VR funds are utilized. The VR counselor may also elect to sponsor services under a concurrent record of service out of other case service funds. VR policy and maximum limits prevail whenever RCC 1281 or other VR funds are utilized. Under no circumstances should either program identify the other as the responsible party without prior coordination and agreement with the other program.

[The 1992 Amendments to the Rehabilitation Act of 1973, Section 102 (a)(4)(B); 34 CFR 364.27]

Section 1-14: Client Signatures

Clients are required to sign many Division forms to either affirm their participation in developing the form or that they received a particular document from the counselor. Signatures may be of the client or, if appropriate, a parent, guardian, or an individual with power of attorney for the client. If the individual has a guardian or power of attorney, a copy of this documentation shall be filed in the individual's case record. If the client with a disability has not yet reached the eighteenth birthday and is not a legally emancipated minor, then additional signatures must be secured. If the client is under eighteen and has been adjudicated a ward of the State, then an adult who is involved with the client must sign required documents. Specific requirements are noted in appropriate polices. If the individual is unable to write his/her signature due to a physical impairment, the individual may use a signature stamp, computer generated signature, or "X" to represent the individual's signature on Division forms.

Section 1-15: Imprest Cash Fund

The imprest cash fund is a fixed sum of money available to meet emergency service delivery needs of clients. This fund is to be used for client services only. The fund should not be used to circumvent Division vendor approval requirements, bidding procedures, or used to provide any service that is subject to rates not established by the Division. At the beginning of each state fiscal year, each VR program unit office which requests an imprest cash fund is allocated a fixed amount of funds out of this budget. This budgeted amount remains constant until approval is received from the Assistant Director for Fiscal Services. Unit managers, or designee, must maintain the local fund in relation to expenses and reimbursements. Under no circumstances is the local fund to show a negative balance without prior permission from the Assistant Director for Fiscal Services.

Procedure for Use of Imprest Cash Fund

1. The Unit Manager will issue a check to the client in the client's name.
2. A case service authorization will be issued in the amount of the check to:
   VSTIF-Vocational Rehabilitation Services (office name), PO Box 26053 Raleigh, NC 27611
3. A case service invoice will be prepared using the same address as above.
4. The client must sign a receipt indicating that the check was

received and for what purpose. The receipt must be forwarded to case service accounting along with the invoice.

5. The same staff person should not sign the check, case service authorization, and invoice.

[Budget Manual 5.3 - Fiscal Policies and Regulations, Imprest Cash Fund]

Section 1-16: Vendor Review and Certification

1-16-1: General Provisions

Each year a training session on nondiscrimination compliance/vendor reviews is held for the Assistant Regional Directors (ARDs). The ARDs conduct similar sessions for regional management teams who in turn train counselors and other appropriate staff. Designated Division staff are responsible for conducting on-site vendor reviews of all in-state vendors being considered for utilization during the rehabilitation process.

An appropriate vendor review form must be signed by the reviewer and the unit manager. This form must also include the signature of the vendor indicating that the vendor is in compliance with all nondiscrimination legislation. The form is then sent to the Assistant Regional Director (ARD) for signature. The Assistant Regional Director (ARD) reviews the vendor information and if there are no nondiscrimination compliance issues or accessibility/communication compliance issues, sends it to the state office. If there are problems in one of the above areas, the ARD will attempt to resolve them and will contact the Section Chief for Program Policy, Planning and Evaluation if there are difficulties in remedying some nondiscrimination compliance/ accessibility issues. The Section Chief for Program Policy, Planning and Evaluation may approve a plan, containing specific time lines for the correction of the problem, under which the vendor may be conditionally approved. The Section Chief for Program Policy, Planning and Evaluation approves, conditionally approves, or denies approval and notifies the vendor. The Chief sends a copy of the approval or conditional approval or denial letter to the appropriate Counselor, Unit Manager, ARD and upon approval adds the vendor to the vendor compliance list.

Authorizations to a vendor will not be accepted prior to approval of that vendor by the Section Chief for Program Policy, Planning and Evaluation. New vendors also sign a statement on the *Form DVR-0304*, *Form DVR-0308*, and *Form DVR-0309* vendor forms indicating that the vendor will not charge the client if an authorization from the agency has been accepted unless the amount for such service charge or payment is previously known to and approved by the Division. Approval is made for these limited situations by the Assistant Director for Fiscal Services and is not subject to negotiation by field staff.

A W-9 must be attached to vendor review applications in order for the vendor application to be processed. A *DVR-0306* is not required for any vendors who

have completed one of the four vendor review forms listed below.

The following vendor review forms can be obtained on the Division of Vocational Rehabilitation Services Intranet Website:

- *Form DVR-0303, Boarding Facility-On-Site*
- *Form DVR-0304, Miscellaneous Vendor Review-On-Site*
- *Form DVR-0308, Application for Vendorship of Professionals-On Site*
- *Form DVR-0309, Application for Corporate Group of Professionals-On Site*
- *Form DVR-0306, Certificate of Nondiscrimination Compliance.*

Private interpreting agencies must be reviewed utilizing *DVR-0304, Miscellaneous Vendor Review-On Site*; however, a vendor review is not required for individual interpreters.

A computerized *Vendor Compliance List* is maintained for information purposes and as a tool to delete the names of vendors not utilized. Questions should be directed to the ARDs or the Section Chief for Program Policy, Planning and Evaluation.

Although an on-site vendor review is not required, a *DVR-0306* must be signed by the following types of vendors:

- Day care programs
- Transportation vendors, i.e., taxi companies, and bus lines, etc.
- Vehicle modifications and repair vendors
- Building contractors (licensed general contractors are preferred). State law requires that persons, firms, or corporations constructing projects costing $30,000 or more to be licensed with the Licensing Board for General Contractors.

Vendors must indicate compliance with all Federal laws related to nondiscrimination based on race or national origin, sex, age, or disability by signing a vendor form. If, at any time, a staff member finds that an approved vendor is not in compliance with the nondiscrimination legislation, it is the staff member's responsibility to discuss the matter with the unit manager and document the concern in writing. The vendor will be offered the opportunity to correct the problem. Should the correction not be made, a report must be sent to the ARD who will review the matter and forward recommendations to the Section Chief for Program Policy, Planning and Evaluation. Any vendor who is in violation of nondiscrimination legislation will receive a letter from the Section Chief for Program Policy, Planning and Evaluation advising the vendor that it has been removed from the approved vendor compliance list and of action required of the vendor prior to consideration for reinstatement with the Division.

The Division may cease to utilize any facility or program when the Division determines that a facility or program fails to meet the individualized rehabilitation

needs of Vocational Rehabilitation clients. The Unit Manager must investigate and advise the vendor of the concerns of the Division, and the two parties must agree upon a plan to correct them. Should the vendor fail to make the necessary improvements, the Unit Manager will forward recommendations to the ARD to remove the vendor from the approved list. The ARD will review and, if in agreement forward such recommendations to the Section Chief for Program Policy, Planning and Evaluation who will remove the vendor from the vendor compliance list.

[10A NCAC 89C .0402; Vocational Rehabilitation Act of 1973, as amended; Civil Rights Act of 1964; 10A NCAC 89C .0403 and 10A NCAC 89D .0101 through – 34 C.F.R .364.55; State Plan, Section 4.9(c)]

1-16-2: Acupuncturists

These vendors must be licensed by the N. C. Acupuncture Licensing Board. They must complete a *DVR-0304* and be approved by the Section Chief for Program Policy, Planning and Evaluation.

1-16-3: Chiropractors

These vendors must be licensed by the N. C. Board of Chiropractic Examiners. They must complete a *DVR-0304* and be approved by the Section Chief for Program Policy, Planning and Evaluation.

1-16-4: Day Care

Counselors may authorize only to such businesses that are licensed or registered by the North Carolina Department of Health and Human Services, Division of Child Development. The day care center should display the license or registration certificate. Before authorizing day care services, the counselor must obtain the license or registration number. A notation of the licensure or registration must be entered in the case record. Comparable benefits must be used when available. The day care programs must complete a *DVR-0306*. Questions regarding day care services should be directed to the Section Chief for Program Policy, Planning and Evaluation.

1-16-5: Dentists

Dentists must be approved by the N.C. State Board of Dental Examiners. A DVR-0308 must be completed and approved by the Section Chief for Program Policy, Planning and Evaluation.

[10A NCAC 89D .0302]

1-16-6: Driver Rehabilitation Specialists

The driver rehabilitation specialist (DRS) is an individual who is licensed, trained, and experienced in evaluating the driving abilities of individuals with disabilities. The DRS must be proficient in the application and operation of modified driving equipment as well as in driver evaluation and training tools. In order to purchase driver evaluation or driver training services, the Division requires a DRS to possess the following minimum qualifications:

A. Current certification as a Certified Driver Rehabilitation Specialist (CDRS); AND
B. Current licensing or registration of one or more of the following credentials: NC Licensed Occupational Therapist (OT/L), NC Licensed Physical Therapist (PT), Registered Kinesiotherapist (RKT), or NC Licensed Recreational Therapist (LRT); AND
C. A minimum of one (1) year, documented, full-time experience in one or more of the services defined in this section to individuals with disabilities consistent with the population they wish to serve.

OR

A. Current licensing or registration of one or more of the following credentials: NC Licensed Occupational Therapist (OT/L), NC Licensed Physical Therapist (PT), Registered Kinesiotherapist (RKT), or NC Licensed Recreational Therapist (LRT); AND
B. A minimum of three (3) years documented full time experience in one or more of the services defined in this section to individuals with disabilities consistent with the population they wish to serve.

1-16-7: Hearing Aid Vendors

Such vendors must sign a Letter of Agreement with the Division indicating acceptance of payment rates and other requirements. They must be licensed by the N.C. State Hearing Aid Dealers and Fitters Licensing Board. These vendors must also complete a *DVR-0304* and be approved by the Section Chief for Program Policy, Planning and Evaluation in the State Office.

[10A NCAC 89D .0306]

1-16-8: Massage and Bodywork Therapists

These vendors may render services prescribed by a physician. Therapists must be in compliance with any local ordinance that pertains to such vendors and must be licensed by the North Carolina Board of Massage and Bodywork Therapy. These vendors must complete a *DVR-0304* and be approved by the Section

Chief for Program Policy, Planning and Evaluation.

1-16-9: Medical Specialists

A medical specialist must be certified in a specialty recognized by the American Board of Medical Specialists or eligible for certification through post-graduate education, and must be a member of the staff of a hospital approved for participation in the DVRS program. Physicians wishing to provide services should complete the vendor review *Form DVR-0308* or *DVR-0309*, which must be approved by the Section Chief for Program Policy, Planning and Evaluation.

[10A NCAC 89D .0302]

1-16-10: Occupational Therapists

These vendors must be licensed by the N. C. Board of Occupational Therapy. They must complete the *DVR-0304* and be approved by the Section Chief for Program Policy Planning and Evaluation.

[10A NCAC 89D .0302]

1-16-11: Opticians

These vendors must be licensed by the N.C. State Board of Opticians. They must complete the *DVR-0304* and be approved by the Section Chief for Program Policy, Planning and Evaluation.

1-16-12: Optometrists

These vendors must be licensed by the N. C. State Board of Examiners in Optometry. They must complete the *DVR-0308* and be approved by the Section Chief for Program Policy, Planning and Evaluation.

1-16-13: Podiatrists

These vendors must be licensed by the N.C. Board of Podiatry Examiners. They must complete a *DVR-0308* and be approved by the Section Chief for Program Policy, Planning and Evaluation.

1-16-14: Prosthetists and Orthotists

The American Board for Certification in Prosthetics must certify these vendors, indicating that the shop meets the Board's various standards. These vendors must complete a DVR-0304, and the form must be approved by the Section Chief for Program Policy, Planning and Evaluation.

[10A NCAC 89D .0307]

1-16-15: Psychologists

The N. C. Psychology Board must license psychologists providing services as VR vendors, and the Section Chief for Program Policy, Planning and Evaluation must approve a *DVR-0308*. In addition to the above, Masters level Psychological Associates also must provide evidence of an active supervisory contract.

[10A NCAC 89D .0304]

1-16-16: Sign Language Interpreters

These vendors must be licensed by the NC Interpreter Transliterator Licensure Board requirements. See Section 2-4-2 for additional information.

1-16-17: Speech and Language Pathologists and Audiologists

Such vendors must be licensed by the N.C. Board of Examiners for Speech and Language Pathology and Audiology. They must complete a *DVR-0304* and be approved by the Section Chief for Program Policy, Planning and Evaluation.

[10A NCAC 89D .0205]

Section 1-17: Medical Consultation

The North Carolina Division of Vocational Rehabilitation Services contracts with practicing physicians to provide consultation services to all unit offices. Consultation is often necessary to interpret, clarify, expedite, and make decisions regarding medical aspects of the case. The responsibilities of the Unit Medical Consultant are as follows:

A. Interpret medical terms and medical information on clients;
B. Clarify and explain physicians' reports in terms of client disability;
C. Assess the adequacy of medical information and advise on the need for specialist consultation or further medical evaluation;
D. Advise on nature and extent of functional impediments and improvement from proposed interventions;
E. Advise on likelihood of residual impediments after treatment;
F. Assess medical prognosis related to rehabilitation potential;
G. Provide staff education regarding disease or injury and current methods of treatment; AND
H. Serve as liaison with colleagues in the medical community.

The consultant's role is to review and advise on medical evaluation and treatment. It remains the counselor's responsibility to determine eligibility,

provide/arrange for all appropriate services and set independent living objectives. All counselors must have access to medical consultation to aid them in proper decision-making and to keep informed concerning current diagnostic and treatment methods. Formal sessions with the Unit Medical Consultant should be scheduled at least once a month and provide for face-to-face meetings with counseling staff for case consultation and staff education. Additional meetings may be scheduled depending upon the need. It is the responsibility of the Unit Manager to schedule, set the agenda for, and conduct medical staff meetings. Case consultation on an interim basis should be obtained by telephone or by a visit to the Unit Medical Consultant's office, as appropriate to the complexity and urgency of the individual client.

Medical situations which must be staffed with the Unit Medical Consultant include those in which:

- Differentiation of an acute versus chronic condition is difficult;
- Unusual studies or treatment are involved;
- A significant disability renders an eligibility determination difficult to establish, e.g. head injury, spinal cord injury, stroke, HIV chronic pain, chronic fatigue syndrome and chronic progressive conditions such as MD and MS;
- An elective hospital admission under VR sponsorship is requested when preadmission certification has been denied for a Medicaid recipient;
- There is question as to the appropriate level of care or reasonable length of stay for specific procedures or conditions;
- Diagnostic/treatment services are requested for a client with suspected/confirmed cancer

[Rehabilitation Services Manual 540.01 - 540.08]

Section 1-18: Subrogation Rights: Assignment of Reimbursement

Subrogation rights legally allow the Division to recoup funds spent in the vocational rehabilitation or independent living rehabilitation of clients who may eventually be compensated for their injury(ies) by another third party. *Form DVR-0104, Subrogation Rights: Assignment of Reimbursement,* must be completed and dispensed prior to the provision of any rehabilitation service which is subject to financial eligibility, and there is a likelihood of future litigated or negotiated compensation from another source. Once *Form DVR-0104* is appropriately completed and dispensed, the Division may sponsor rehabilitation services. At such time a settlement is reached, the Division must reclaim its expenditure. *Form DVR-0104* must be completed under the following circumstances:

- The disability was caused by a personal injury in which an insurance settlement is pending.

- The disability resulted from an occupational injury which is subject to workers' compensation insurance requirements. Since the applicant/client has a right to appeal a denied claim, an Assignment of Reimbursement should be secured when the original claim is denied.
- The applicant/client has health insurance which pays directly to the applicant/client; it is the client's responsibility to notify the counselor of any funds received.
- Any other situation when there is pending litigation regarding the applicant/client's disabling condition.

The individual applying for services must sign the form after it is fully completed. If the applicant is under eighteen, then the parent, guardian, or other legally recognized individual must also sign the form. Failure to sign constitutes failure to cooperate in the Division's legal responsibility to use comparable benefits and financial eligibility requirements thus negating eligibility to receive services based on these contingencies. The form must be notarized. Failure on the counselor's part to fully complete and accurately dispense the form will impede, if not negate, the Division's ability to recoup these funds. Completed forms mailed to the insurance carrier, employer, and attorney must be sent by certified mail.

When requested to supply financial information for settlement purposes, counselors should contact the Information Processing Assistant in the Purchasing and Technology section of the state office for this information which will be communicated to the responsible party as settlement is in progress. All negotiations for partial settlements with the Division must be referred to the Information Processing Assistant. There are two conditions under which the Division will entertain such requests. These are:

A. When there is insufficient money to pay the total Division expenditure leading to a pro rata settlement among all parties having claims against the settlement, AND
B. When the partial settlement would offset future Division expenditures in completing the IPE.

[Rehabilitation Act of 1973, as amended; Federal Rehabilitation Manual, Chapter 2515; 34 CFR 361.63 NC General Statute 143-547]

Section 1-19: Unit Manager Approval

The following require Unit Manager/Facility Director approval:

- All successful closures (case status code 76)
- Any revisions of the case record (as covered under *SECTION 1-3: CONFIDENTIALITY OF RECORDS*)
- Out-of-state services

- Justification for purchase of equipment outside of the state contract
- All requests for exceptions to maximum rates and fees as determined by Division policy (Unit Manager must approve prior to submitting to the Chief of Policy for approval)
- Exceptions to use of comparable benefits
- Cases involving excess financial resources and extenuating circumstances as determined by *Form DVR-0116, Financial Statement*
- Any exception to the requirements for verification of income or verification of payment of allowed deductions on the *Form DVR-0116*
- Retroactive authorizations exceeding 7 days except for ancillary services associated with surgical procedures
- Case Service Invoice overpayment in excess of $100.00
- Equipment purchases in excess of $500.00
- Power Wheelchairs/Scooters
- Residence modifications
- Vehicle modifications
- Vehicle repairs in excess of Division rates
- In-home maintenance
- Personal care assistance in excess of 28 hours per week
- Extension beyond 6 months for sponsorship of medically managed weight loss program
- Purchase of prescription pain medications considered controlled substances beyond 60 days
- Permanent relocation and moving expenses

1-19-1: Rehabilitation Counselor I and Rehabilitation Counselor Trainee

In addition to the requirements at the beginning of this Section, those individuals who have not yet achieved Rehabilitation Counselor II must have the following casework and service delivery forms approved by the Unit Manager, or designee:

- Eligibility Decision
- Ineligibility Decision
- IPIL, Amendments and Progress/Annual Reviews which add support services to the plan.
- IPIL closure documents

At the discretion of the Unit Manager, the Rehabilitation Counselor I may issue:

- Authorizations for services that have been planned and approved without further approval or supervisory sign-off on the authorization or invoice.
- Authorizations for diagnostic/assessment services without supervisory approval or sign-off.

Section 1-20: Applicant/Client Informed Choice

Informed choice is an ongoing process and partnership with an applicant or client

which provides the individual with the opportunity to make decisions and selections regarding their options and methods to secure these services. The ability of the applicant/client to choose, based on a factual knowledge that reveals all available options, and the potential implication of the individual's selection, is instrumental in the successful completion of the rehabilitation program. Division staff will provide the opportunity for applicant/clients to participate in their rehabilitation program by providing information or assisting in the acquisition of information necessary for the individual to make informed decisions throughout the rehabilitation process. Division staff will provide, through the most appropriate means of communication for the applicant/client to make informed decisions throughout the rehabilitation process. Division staff will provide, through the most appropriate means of communication for the applicant/client, information concerning the availability and scope of the various choice, the manner in which decisions may be exercised, and the availability of support services for those applicant/clients who because of their disability need assistance in exercising their options.

Application Phase

The assessment for determining eligibility must be conducted consistent with the applicant's needs and choices. When necessary to provide evaluation services in order to complete the assessment, staff will provide the applicant information necessary to make a choice regarding the service, service provider, and methods to procure the service. Services will be provided consistent with the applicant's informed choice.

Plan Development

Staff will provide clients with information necessary to make decisions regarding alternative goals, objectives, services, service providers and methods to procure services or assist in the acquisition of information necessary to make these informed decisions. Information related to cost, accessibility, and duration potential services will also be provided along with information regarding qualifications of service providers, types of services offered by those providers, and the degree to which services are provided in and integrated setting. Such information will come from state; regional; or locally maintained lists; referrals to other individuals or groups in order to get information, and information related to qualifications and certifications of potential service providers.

Service Delivery

Services will be provided consistent with the full input of the individual applying for or receiving services.

Independence Outcome

The independence outcome will be consistent with the client's informed choice as noted on the IPIL, original or amended.

While working to honor client choices in service planning and delivery, Division staff will apply resources in the most accountable and efficient manner. Only those services necessary to complete the rehabilitation program will be provided by the Division.

[1998 Amendments to the Rehabilitation Act of 1973 Sec.102(b)(2)(B, 34 CFR 361.52, 34 CRF 364.52)]

CHAPTER TWO: NATURE AND SCOPE OF SERVICES

Section 2-1: Nature of Independent Living Rehabilitation Services

The purpose of the Independent Living Rehabilitation Program (IL) is to promote the integration and inclusion of individuals with significant disabilities in the community. The IL program has a priority focus on those individuals with significant disabilities who can manage or learn to manage on their own in the community with services from the program. The IL Program assists eligible individuals with significant disabilities to obtain services to assist with deinstitutionalization, the prevention of institutionalization, achieving community living, and/or employment transition to the Vocational Rehabilitation Services program. The program does not establish or operate permanent living facilities or manage supervised living arrangements, but does strive to facilitate the independence of many who might otherwise be placed in such settings and, perhaps, have less opportunity to realize their fullest potential. The IL program works collaboratively with community resources with emphasis given to coordination and use of those resources to conserve state funds. The provision of services is dependent and contingent upon and subject to the appropriation, allocation, and availability of funds to the IL rehabilitation program.

Section 2-2: Scope of Services

The scope of rehabilitation services available to an individual is determined by the services required by that individual in order to reach the IL goal. All services provided must be directly related to the achievement of the goal established in concert between the client and the Counselor. The client is to play an instrumental role in determining the services received and the source from which these services are received. The Counselor's role is to assure that the client is aware of the service providers and how to access those services; and to provide the services which are within the Division's purview that have been planned with the client. Counseling and guidance is important to maintain a counseling relationship throughout the rehabilitation process, in order to assist individuals to secure needed services from other agencies, and to advise individuals about client assistance programs. All services planned and provided must be documented in the client's record of service. *Case Notes* and other forms are provided for documentation with some forms only available through the use of computers. Counselors are encouraged to use forms which are part of the IPIL system for documentation of services after the development of the rehabilitation plan and to provide clients copies of this documentation. All services listed in this chapter are available for planning towards the accomplishment of the rehabilitation goal. Some services are subject to the client’s personal financial resources or comparable benefits or both, and are so noted. The distinction is

specific to the service being provided not the case status code or where the individual is in the rehabilitation process.

[34 CFR 364.4]

2-2-1: Timeliness of Services

Services must be initiated at the earliest time the service is available and that the client is prepared and available to participate. Circumstances that require the delay of the initiation of services must be documented on the original IPIL or amended IPIL.

If the initiation of the service is later than the projected date and the delay of services is minimal, the circumstance for the delay may be explained on a progress review.

2-2-2: Policy Exceptions

Cross Reference **Section 1-19, Unit Manager Approval**

Exceptions to the policies concerning the provision of services must be approved by the Chief of Policy, unless approval is specifically delegated to the Unit Manager. This includes requests to exceed Division maximums, time limits, and other service selection criteria. The rationale for the exception must be submitted to the Chief of Policy to be reviewed. The Program Specialist for Independent Living will be consulted as needed.

Section 2-3: Assistive Devices and IL Equipment

These services involve the provision of all equipment required for the Individualized Plan for Independent Living (IPIL) including devices or durable medical equipment such as TTYs, wheelchairs, Hoyer lifts, or assistance to obtain these services from other sources. The Rehabilitation Engineer must be involved if the equipment is to be modified to accommodate the individual's disability. Such services are subject to both financial needs criteria and comparable benefits.

Equipment may be purchased under the following conditions:

A. The client has the knowledge to use or can be trained to use the equipment;
B. The equipment is required to meet the client's independent living goal and will be used by the client towards completion of the IPIL; AND
C. The client has the resources to safely store, insure, and adequately maintain the equipment as documented by client signature on *DVR-1015*. This security agreement will remain in effect until the Division at the Unit

Manager's request dissolves the agreement. Such request should not be made until the equipment has been used for at least 5 years or unless unusual circumstances necessitate release of Equipment.

If available items are not suitable for the individual rehabilitation need, the state term contracts must be considered for purchasing if the item costs more than $100.00 or exceeds the cost of the minimum order of the state term contract. If the item needed is not available on a state term contract or if purchase outside the state term contract is justifiable, utilize the informal bid (quotations) procedure described in this section.

[G.S. 143-55]—general purchasing citation

2-3-1: Appliances

The IL program may assist with the purchase of appliances for purposes of deinstitutionalization, first time relocation to accessible housing, or to overcome environmental barriers related to functional limitations. The need for appliances must be related to the individual's functional limitations as documented in the case record by the appropriate specialist. The provision of basic appliances may include:

- Microwave
- Window air condition unit
- Washer and Dryer
- Refrigerator

The purchase of these items is sometimes necessary to assist an IL participant in maintaining or regaining independence and is subject to the individual's financial need and comparable benefits.

2-3-2: Assistive Technology Devices

An assistive technology device is any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve functional capacities of individuals with disabilities. The provision of this service is subject to the individual's financial need and comparable benefits.

[The 1992 Amendments to the Rehabilitation Act of 1973, Sec. 103 (13); 34 CFR 364.4; 34 CFR 361.5]

2-3-3: Computers

The Division will participate in the purchase of computers if assistive technology is required by the client for purposes of augmentative communication, environmental controls, or when voice recognition or equivalent adaptive input

devices are required for the individual to complete the IPIL. The Chief of Policy must approve the entire system including computer and assistive technology.

Division assistance will be limited to $500.00 for software unless the software is required in one of the cases named above. The Division will not purchase upgrades or improved versions of assistive technology following the initial purchase, unless the individual can no longer use the device because of a significant change in their disability. The Chief of Policy must approve exceptions.

[10A NCAC 89C .0305]

2-3-4: Durable Medical Equipment

CROSS REFERENCE: **Interim Policy and Procedure Directive #06, *Durable Medical Equipment***

Durable medical equipment (DME) is that which (a) can withstand repeated use; (b) is primarily and customarily used to serve a medical purpose; (c) generally is not useful to a person in the absence of an illness or injury; and (d) is appropriate for use in the home. A prescription is required to purchase equipment over $100.00, and it must be included with the authorization or purchase order and specifications to the vendor. See DME purchasing procedures in this section for more information (2-3-8).

[34 CFR 364.4; NC G.S. 143-53; NC G.S. 143-55; §1861(s)(6) of the Social Security Act]

2-3-5: Furniture and/or Furnishings

The IL program may assist with the purchase of furniture and/or furnishings for purposes of deinstitutionalization, first time relocation to accessible housing, or to overcome environmental barriers due to a change in functional limitation. A basic furniture package may include:

- Small Couch or loveseat, or chair
- Small Coffee or End table
- Small Dinette Table with maximum of four chairs.
- One Twin, Full, or Queen Size bed with mattress and box spring.
- Chest of Drawers or Dresser
- One Nightstand

A basic furnishing package may include the following:

- 2 sets sheets
- Mattress cover
- 2 Pillows
- 1 Comforter or Bedspread

- 1 Blanket
- 1 bedside lamp
- 2 Bath towels, 2 hand towels, 2 washcloths,
- 1 shower liner and hooks
- 1 living room lamp
- Maximum set of 4 plates, 4 bowls, 4 mugs, 4 glasses, 4 sets of utensils
- 1 basic set of pots and pans, cooking utensils, mixing bowls

2-3-6: Recreation Equipment

The IL program may assist with the purchase of recreation equipment when recreational services are being provided to support a recreational goal on the IPIL. Services are subject to financial need and comparable benefits.

2-3-7: Telecommunicative Devices

The Division will evaluate the needs of all eligible sensory impaired clients for telecommunications, sensory, and other technological aids and devices. These services include the widest range of electronic or assistive listening devices, are available and have demonstrated an ability to aid a person's chances of going to work or living more independently. Assistive listening devices include hardware devices, FM systems, loops, infra-red devices, direct audio input hearing aids, telephone aids and speech assistance devices. Such services are subject to an individual's financial need and comparable benefits, when available. Individuals needing telecommunication systems and devices should be referred to the Assistive Technology Consultant for the Deaf who will contact and involve appropriate Division resources and vendors prior to assessing client need and making recommendations. The counselor should submit an authorization to the North Carolina Assistive Technology Program for services rendered. Contact the North Carolina Assistive Technology staff for rates.

Requirements for purchasing such devices are as follows:

A. The client must have a telephone or be able to afford the cost of telephone installation, monthly bill and maintenance in order to receive assistance with assistive devices requiring a telephone.

B. Text Telephones-Teletypewriters (TTYs) and other assistive devices are not registered with property control unless costing $500 or more. However, the client must sign *Form DVR-1015 - Acknowledgment/Equipment Security Agreement* indicating that the device remains the property of the Division for a period of five years from the date of purchase and that the device must be used as indicated in the IPE/IPIL. The Division will maintain ownership of all assistive listening devices, and will repossess all assistive devices if the client discontinues their use as outlined in the IPE/IPIL.

Comparable Benefits

The Division of Services for the Deaf and Hard of Hearing has the Equipment Distribution Service, which provides access to telecommunications devices for people who are Deaf, Hard of Hearing, Deaf-Blind, and Speech Impaired but whom have difficulty affording these devices.

The Equipment Distribution Service Hearing Aid Program provides one hearing aid that allows individuals with hearing loss to communicate on the telephone using a hearing aid telecoil (T-coil). The goal is to provide equal access through the telephone system and Relay Service. Devices are free to qualified individuals.

Types of Devices Available Through the Equipment Distribution Service:

- TTY
- Loud Ringers
- Volume Amplifiers
- Large Visual Displays
- Artificial Larynx
- Stutter Inhibitors
- Light Phone Signalers
- Other

Types of Hearing Aids Available Through the Equipment Distribution Service Hearing Aid Program: (one hearing aid per person)

- Digital Hearing Aid
- Analog Hearing Aid
- Behind-the-Ear Hearing Aid
- In-the-Ear Hearing Aid

To apply, contact one of the following sources:

- the Division of Services for the Deaf and Hard of Hearing in Raleigh
- the Regional Resources Center in your area
- or the Rehabilitation Counselor for the Deaf in your area

[10 NCAC 89C.0310; 34 CFR 364.4)—general definition of IL Services

2-3-8: Procedures to Purchase Durable Medical Equipment

A prescription is required to purchase durable medical equipment and must be included with the authorization or purchase order and specifications to the vendor. For purchase of Durable Medical Equipment that is on a State Term Contract, the Rehabilitation Counselor must purchase the equipment using the established rate, or in the absence of such, the Medicaid rate. The normal bidding process does not apply since the Division is limited to paying a fixed rate.

Approval by the Chief of Policy is not required when purchasing Durable Medical Equipment costing $2501.00 or greater on State Term Contract or when using an established Medicaid rate. The Counselor issues the authorization to a State Term Contract vendor or, with justification approved by the Unit Manager, a vendor outside of the state term contract process that accepts the State Term Contract or Medicaid rate, whichever is greater.

Moreover, purchase of Durable Medical Equipment from a state contract vendor is required when the specific item is available through this means. If equipment is not available through the State Term Contract, or justification for purchasing outside of the state contract is approved by the Unit Manager, the counselor in partnership with the client selects a reputable dealer and issues authorization for the item using the established State Term Contract rate, or in the absence of such, the Medicaid rate (In some instances, state contract rates are negotiated at a slightly higher rate than the established Medicaid rate).

Comparable benefits must be utilized when available in the purchase of Durable Medical Equipment.

The following procedures apply to the purchase of Durable Medical Equipment that does not have an established Medicaid rate or State Term Contract rate:

Durable Medical Equipment Without an Established Medicaid Rate Costing $2501.00 or more (Wheelchairs, Scooters, etc.)

1. A prescription is required in order to purchase.
2. Comparable benefits must be utilized when available.
3. The Unit Manager reviews and provides initial approval for the request for purchase of equipment.
4. If the UM approves, the request is forwarded to the Chief of Policy for final review and approval. If approved, the Chief of Policy, in consultation with the Fiscal Services and Purchasing Sections, will determine the rate of payment and method of purchase.

Durable Medical Equipment Without an Established Medicaid Rate Costing $2500.00 or less*:*

1. A prescription is required in order to purchase.
2. Comparable Benefits must be utilized when available.
3. The Unit Manager reviews and approves the requests for purchases greater than $500.00.
4. The Rehabilitation Counselor contacts Fiscal Services (mailto:dvr.m.fiscalservices@dhhs.nc.gov) for consultation on setting the rate of payment.
5. The Rehabilitation Counselor issues the authorization for the Durable Medical Equipment.

For all other Durable Medical Equipment and Medical Equipment, the Medicaid rate or the Division's set rate will be paid. If there is no rate, contact Fiscal Services (dvr.m.fiscalservices@dhhs.nc.gov) for clarification of the Medicaid rate or for the Division's set rate.

2-3-9: Procedures to Purchase Other Equipment

CROSS REFERENCE: **Interim Policy and Procedure Directive #06, *Durable Medical Equipment***
Section 1-19, Unit Manager Approval
Section 2-12-1, Hearing Aids

All equipment that costs more than $100.00 or that exceeds the cost of the minimum order for the state term contract must be purchased from mandatory state term contracts unless there is a valid justification. Any item provided by the NC Department of Corrections (Correction Enterprises) must be obtained from Correction Enterprises. Firearms will not be purchased for any reason. Each client receiving equipment that costs more than $500 will be required to sign *Form DVR-1015, Acknowledgement/Equipment Security Agreement* indicating Division ownership and lien information. All equipment remains the property of the Division until such time as it is released by the Division. Available repossessed equipment will be considered before the purchase of new equipment.

In accordance with State Purchasing and Contract rules, the following purchasing procedures have been developed based on the cost of the equipment.

Definition

EQUIPMENT PURCHASING PACKET: A packet of information submitted to the state office which includes the following:

* The client's full name and VR/IL number
* Primary disability code
* The VR/IL office location
* The caseload code
* The client's mailing address
* The delivery address for the equipment (include county)
* The specific equipment to be purchased, with the cost, manufacturer, model number, part and/or serial number, and quantity, with a copy of the vendor brochure or literature
* Justification for purchasing outside of the State term contract
* Justification for single sourcing if it is requested
* Prescription for durable medical equipment in order to be exempted from state sales tax

Equipment Costing $100.00 or Less OR Items Purchased Below the Required Minimum for the Individual State Contract

- Equipment or supplies that cost $100.00 or less or do not meet minimum order for the state term contract may be purchased from the most suitable source. Individual contracts should be referenced for the minimum order amount.
- Quotations are not required, but comparison of costs for the most cost-effective solution is expected and must be documented in the case record.

EXAMPLE: The minimum order for metal storage units is $250.00; so metal storage units that cost less than $250.00 may be purchased outside of the state contract without justification.

Equipment Between $101.00 and $500.00

- Mandatory purchase from state term contract unless justified
- If purchased outside the state term contract, justification must be maintained in the case record.
- Quotations are not required, but comparison of costs for the most cost effective solution is expected and must be documented in the case record.
- Counselor issues an authorization directly to the vendor on state term contract or, if justified, to the lowest bidder.

For Equipment Costing Between $501.00 and $2,500.00

- Mandatory purchase from state term contracts unless justified.
- The Unit Manager will approve the request for purchasing the equipment.
- Justification for purchasing outside the state term contract must be approved by the manager and the documented justification maintained in the case record.
- If the equipment is not available through state term contract or justification for purchasing outside the state term contract is approved by the Unit Manager, a minimum of three (3) quotations is required. Quotations (Informal bids) may be written, faxed or verbal and must be maintained in the case record.
- Counselor issues an authorization directly to the vendor on state term contract or, if justified and approved to the lowest bidder.

For Equipment Costing $2,501.00 or More

- Mandatory purchase from state term contracts unless the equipment is not covered by state term contracts or purchase outside the contract is justified.

- A narrative explanation to request the purchase will be prepared by the Counselor and approved by the Unit Manager/Facility Director.
- If purchase outside the state term contract is justified and approved by the Unit Manager/Facility Director, this justification will be included in the purchasing packet.
- The Unit Manager's/Facility Director's approval, the narrative and the PURCHASING PACKET will be forwarded to the Chief of Policy.
- If approved, the Chief of Policy will forward the PURCHASING PACKET to the Purchasing Unit.
- The Purchasing Unit will be responsible for purchasing from the state term contract and all bidding and purchasing procedures for equipment purchased outside the state term contract.
- The Purchasing Unit will issue the purchase order to the vendor and send a copy to the Counselor.
- The Counselor will generate an authorization for the case file and to attach to the invoice. The Counselor will attach a copy of the purchase order to the authorization in the file and to the invoice for processing. **If a purchase order is issued, the authorization must not be sent to the vendor as this often results in duplicate orders and confusion.**

Procedures for Purchasing Equipment on the State Term Contract

Information regarding vendors who have been awarded state term contracts is available through the State Purchase and Contract Web Site at:

www.doa.state.nc.us/PandC/

To utilize the web site:

1. Logon to the State purchasing internet site.
2. Select Term Contract link.
3. Utilize the "Term Contract Key Work Listing" and press "Go."
4. Click on the key word for the equipment.
5. On each contract site review the information available regarding scope of contract, discounts and details for making an order. Information is available that will help you clarify equipment specifications to the vendor. For example, in the contract for Venetian Blinds there is a section on "Taking measurements."
6. Note the minimum order information (Usually #5 on the contract).

There is very little on-line pricing information available. Vendors' websites could be used for pricing ideas. In addition, there is the option to utilize the e-procurement search feature by clicking on "non-system user" and typing in the item that you would like to price. However, this is a time-

consuming process that requires many refined searches to actually price one item at a time.

At this time, the most practical procedure is as follows:

1. Click on “Contractors” in each contract site.
2. Select one or more contractors from whom you would like prices
3. Attach the specifications for the equipment or list of equipment and email the contractor asking for prices for this item. (There is an email link on the contractor list.)
4. If there is undue delay in the response of the contractors, call the purchasing unit for assistance.
5. Delay in response from contractors or delivery may be a justification for purchasing outside the contract if the client needs the equipment immediately.

There is no requirement for getting quotations or bids for items purchased through the state term contracts; however, locating the best price for the type of equipment required by the client will be best achieved by contacting several vendors who are on the state term contract for the prices of equipment needed by your client. If a contractor consistently meets the needs for equipment, there is no requirement to contact multiple vendors for each purchase.

Purchasing Outside of the State Term Contract

All purchases made outside the state term contracts that cost over $100.00 or exceed the cost of the minimum order for state term contracts must be justified utilizing the following state statute.

The procedure is as follows:

1. For items $500.00 or less dollars, no quotations or bids are required. Compare catalogs, price lists and discounts in order to find the most cost-effective solution and document the comparison of costs in the case record.
2. A minimum of three (3) quotations (informal bids) should be sought for purchase of training, placement and IL equipment that costs between $500.01 and $2,500. Bids may be written, faxed, or verbal. Telephone quotations, from vendors are acceptable if the vendors are identified and the quoted prices are maintained in the client record. All bids and quotes received must be maintained in the client record. The proposed purchase must be discussed with and approved by the Unit Manager.
3. Form *DVR-0194*, Wheelchair Request and the Execution of Bid must be completed for wheelchair purchases. In lieu of page 1 of *DVR-0194*, comparable specifications may be substituted. Bids may be written or faxed as described above.

4. All equipment requests over $2,500 must be forwarded to the Purchasing Unit for purchase from the state term contract or for execution of the bid process.

Purchases for Persons with Disabilities

To comply with state purchasing laws related to persons with disabilities, the Rehabilitation Act of 1973, as amended, and the American with Disabilities Act, as amended, the Division shall allow for the following:

A. The involvement of the individual in the choice of particular goods, service providers, and in the methods used to provide the goods and services;
B. The flexibility necessary to meet those varying needs of individuals that are related to their disabilities;
C. The purchase outside of certified sources of supply (state contract) and the waiving of competition when a single source can provide multiple pieces of equipment, including adaptive equipment, that are more compatible with each other than they would be if they were purchased from multiple vendors;
D. Priority consideration to suppliers offering the earliest possible delivery date of goods or services especially when a time factor is crucial to the individual's ability to secure a job, meet the probationary training periods of employment, continue to meet job requirements, or avoid residential placement in an institutional setting; AND
E. Consideration of the convenience of the provider's location for the individual with the disability.

The following criterion shall also be considered:

- Cost-effectiveness
- Quality
- The provider's general reputation and performance capabilities
- Substantial conformity with specifications and other conditions set forth for these purchases
- The suitability of the goods or services for the intended use
- The personal or other related services needed
- Transportation charges
- Any other factors pertinent to the purchase

[G.S. 143-53; State of North Carolina Agency Purchasing Manual (VII-6)]

2-3-10: Equipment Repairs

Equipment repairs may be sponsored if such repairs are required in order to complete the rehabilitative program or as part of a post employment/closure plan. Counselors should secure several quotes of repairs estimated to be $200.00 or

less and may approve such repairs. Repairs estimated to exceed $200.00 should be purchased through the bid process. Unit Manager/Facility Director approval is not required for equipment repairs. However, Counselors should be aware of the cost of the repairs in relation to the value of the equipment being repaired. This service is subject to financial need and comparable benefits.

Section 2-4: Assistive Technology Services

This service is defined as any service that directly assists an individual with a disability in the selection, acquisition, or use of an assistive technology device. The provision of this service is subject to the individual's financial need and comparable benefits.

[34 CFR 364.4; 34 CFR 361.5]

Section 2-5: Communication Services

These services are provided to enable the client to better communicate with other people. These services include, but are not limited to, foreign language translator and interpreter services, interpreter services (sign language & oral), tactile interpreter services for individuals who are deaf and blind, cued speech services, Braille training, reader services and training in use of communication equipment. Communication accessibility may be required at any time during the rehabilitation process in order to allow the individual to have access to all rehabilitation services.

2-5-1: Foreign Language

Title VI of the Civil Rights Act of 1964 is the Federal Law that protects individuals from discrimination on the basis of their race, color, or national origin in all programs that receive Federal Financial Assistance. Title VI requires linguistic accessibility to health and human services. Therefore foreign language interpreters/translators will be sponsored at any time during the rehabilitation process when the applicant/client is unable to understand either verbal or written information presented by the Division.

The U. S. Office for Civil Rights has interpreted Title VI to require all recipients/agencies receiving federal funds to implement the following specific guidelines:

A. The Counselor is responsible for determining the client's preferred language and providing a qualified foreign language interpreter/translator at the earliest possible opportunity before or after the initial contact with the Division.

B. IL forms are available in Spanish for individuals with Limited English Proficiency (LEP). The Counselor may contact the Specialist for the Deaf and Hard of Hearing/Communicative Disorders for assistance in locating a qualified interpreter/translator for Spanish.

C. Interpreters/Translators for all languages must be qualified and trained with demonstrated proficiency in both English and the native language of the client. The Membership Directory of the Carolina Association of Translators and Interpreters is available at:

http://www.catiweb.org/;

however, it is not required that all qualified interpreters/translators be listed in this directory.

D. IL must offer translation services at no cost to the person with Limited English Proficient (LEP). Rates for foreign language interpreting services are listed in Volume V. The Unit Manager/Facility Director can approve exceptions. A minimum of two-hours will be authorized per session. Such services are not subject to the financial need criteria; however, comparable benefits must be used when available. Travel and approved per diem may be authorized according to the allowable IRS rates paid State employees.. Authorization should state foreign language interpreting services. IL counselors must use their regular caseload budget to authorize for foreign interpreting services.

E. Interpreter/Translator services must not be authorized to a member of the consumer's family. Minors (age 18 or under) shall not be used to interpret.

F. Information to verify identity and employment eligibility is in Section 1-9.

2-5-2: Interpreting Services (Sign Language and Oral)

The Americans with Disabilities Act (ADA) has set our sights on removing the barriers that deny individuals with disabilities an equal opportunity to share in and contribute to the vitality of American life. The ADA means access to jobs, public accommodations, government services (VR & IL), public transportation, and telecommunications – in other words, full participation in, and access to, all aspects of society (Dunne, 1990).

IL Counselors may obtain an assessment from a Rehabilitation Counselor for the Deaf to determine a client's mode of communication to ensure than an appropriate interpreter is employed to meet the client's communication needs before diagnostic and evaluation services are begun or anytime throughout the rehabilitation process. Such services are not subject to the financial need criteria; however, comparable benefits must be used when available. The assessment for determining eligibility and rehabilitation needs should determine the client's ability

to communicate, and the IPIL should note any potential need for interpreting services.

The Division may also provide sign language instruction for clients who are deaf on an individual or group basis when this service is an essential part of the IPE. Interpreters may be provided during the appeals, mediation, and administrative review process.

Interpreters may be provided during appeals, mediation, public hearings, and administrative review process.
All freelance interpreters and private interpreting agencies utilized by the NCDVRS must be licensed by the North Carolina Interpreters and Transliterators Licensure Board. Educational Interpreters utilized by NCDVRS must be licensed by the Board or meet the certification requirements established by the National Registry of Interpreters for the Deaf. (See Volume V for rates for interpreting services).

The following types of interpreting services may be used:

A. Sign language interpreting – ASL, signed English, or pidgin, the interpreter "visually" relays the spoken word to the student in whatever sign system is agreed upon.
B. Oral interpreting – the interpreter 'mouths' the words spoken for the deaf or hard of hearing student. Sign language may sometimes be used as filler.
C. Tactile interpreting – is used by deaf-blind students who need to 'feel' the formation of signs that the interpreter is making. The student places their hands on the interpreter's hands while interpreting. Some students can also use on-the-palm printing.
D. Low-vision interpreting – is used by deaf/low-vision students who cannot see the interpreter from a distance. The interpreter and student face each other at a closer distance to enable the student to see the interpretation.

Payment for Freelance Interpreters (See Educational Interpreting, Special Programs – Deaf Students)

The Division has adopted the guidelines and the pay scale established by the Department of Health and Human Services' Approved Interpreters List. The Division has an ascending pay scale as delineated in Volume V for licensed interpreters, private interpreting agencies, and educational interpreters.

- The counselor should utilize an interpreter with full state license when possible.
- Normal reimbursement rates will apply during weekdays between the hours of 7:00 am to 5:00 p.m. During all other times and days, and during State recognized holidays,

reimbursement will be at the rate of one and one-half times the normal rate.

- Time and one-half will also apply to last minute or emergency requests with twenty-four (24) hours or less notice.
- Interpreters will be paid for a minimum of two hours per assignment.
- Mileage may be authorized at the allowable IRS rates for State employees.
- Per diem expenses may be authorized at the allowable rates for State Employees with advance approval from the counselor or the unit manager.

Independent Living and Interpreting Services

IL staff serving Consumers who are deaf should contact the Program Specialist for the Deaf and Hard of Hearing in the State Office for consultation and/or instructions on how to authorize for interpreting services.

[34 CFR 364.4; NCAC 89C 0308]

2-5-3: Reader Services

Generally if a client needs reader services, the Division of Services for the Blind will serve this client and provide these services. However, if a client served by IL needs reader services, contact the Program Specialist for the Deaf and Communicative Disorders for assistance. Reader services are authorized out of the counselor's regular budget.

Section 2-6: Counseling and Guidance

These services cover an array of counseling and guidance issues for Division clients that could be general, or specific and substantive in scope. Services in this category are not subject to financial need or comparable benefits. Supportive "counseling and guidance" is an integral part of any rehabilitation program and may be provided at any time during the rehabilitation process. Counseling and guidance provided as a substantial service is distinct from the general or supportive counseling relationship that exists between the counselor and client. The guidance and counseling planned must be anticipated to result in a functional change in the client's primary IL objective and must be accompanied by other rehabilitation services.

The following are examples of guidance and counseling interventions:

- Helping the individual understand their diagnosis/impairment and functional limitations
- Assisting the individual in dealing with and adjusting to the emotional issues surrounding their disability
- Liaison or interventions with medical providers to facilitate individual's

treatment and meet medical needs
- Discussion and exploration of an individual's strengths, interests, and abilities in relation to the recommendations from assessment data and other case information

Section 2-7: Driver Evaluation and Training

CROSS REFERENCE: **Section 2-10, Rehabilitation Technology**
Section 1-16-18, Driver Rehabilitation Specialists
Appendix Entry-Counselor's Driver Evaluation and Training Process

Handbook: Counselors shall utilize the "Counselor's Driving Evaluation and Training Process" located on the intranet.

Driver evaluation and training may be sponsored for those clients who require such training in order to obtain a driver's license. If the individual has never had a license, had the license revoked, or cannot get the license renewed due to the development of a disability, it may be necessary to secure both evaluation and training prior to getting a license.

Individuals who have cognitive, visual, or other physical impediments with questionable driving ability or restrictions must receive such evaluation and training prior to the Division agreeing to purchase and/or modify a vehicle. Any individual requesting driving control modifications, including hand controls and left foot accelerators, must complete a driving evaluation prior to modifications to their vehicle, except when all three of the following conditions are met generally for purposes of providing replacement equipment:

A. The individual has previous and current experience driving with driving control modifications; AND
B. The individual's disability is stable; AND
C. The individual is requesting functionally equivalent modifications.

The evaluation must be conducted by a driver rehabilitation specialist, an individual who is licensed, trained, and experienced in evaluating individuals with specific disabilities. Individuals who have never had a driver's license are required to pass the written and eye examinations and to obtain either a driver's permit or a "Restricted Driving Permit" prior to participating in an in-vehicle evaluation or training. Financial need and comparable benefits must be determined prior to the initiation of the training phase.

[34 CFR 361.42(a)(16)]

Section 2-8: Information and Referral

This service includes those activities designed to coordinate services and benefits available in the community. Referrals to public programs can include Vocational Rehabilitation, other DHHS Divisions and agencies, Medicaid, housing authorities, and social services. Referrals to private programs can include Centers for Independent Living, civic organizations, religious organizations, home health agencies, and private contractors. Services in this category are neither subject to financial need nor comparable benefits.

[34 CFR 364.4]

Section 2-9: Maintenance

Maintenance means monetary support provided for those expenses such as food, shelter and clothing that are in excess of the normal expenses of the individual, and that are necessitated by the individual's participation in an assessment for determining rehabilitation needs or while receiving services under an IPIL. Maintenance is not intended to pay for those living expenses that exist irrespective of the individual's involvement with rehabilitation. Rather maintenance is a limited service designed to assist the individual with meeting the additional costs incurred while participating in a rehabilitation program. Financial need must be determined except in those situations when maintenance is required in support of an assessment service required to determine eligibility or rehabilitation needs. Comparable benefits must be used when available. Maintenance services include:

- Basic payments while client is in travel status to obtain services
- Basic payments (room, board, incidentals) for increased independence in situations such as deinstitutionalization or a move to accessible and/or affordable housing.

NOTE: Unit Managers must review and sign all case service authorizations for maintenance when the client lives in their home or in the home of a family member. All exceptions to the Division's maximum limits for maintenance must be approved, in advance, by the Chief of Policy.

Section 2-10: Modifications

In order to assist an individual in increasing their independence, the Division may assist with modifications of the home, vehicle, or, in joint cases with VR where there is an employment goal, workplace modifications. All modifications are subject to the individual's financial need and comparable benefits. The Chief of Policy is responsible for approving all modification projects exceeding Unit Manager approval maximum rates and involving Division funds. In joint cases

where modifications of any type are being funded out of VR funds, VR policy prevails.

Definitions

PURCHASING MANAGER: The Purchasing Manager is responsible for arranging the bidding and purchasing procedures for all modifications (except as noted in 2-10-2-Vehicle Modifications).

CLIENT DATA PACKAGE: A package of information prepared by the Counselor and submitted to the Chief of Policy on all modification proposals $500 and above. For vehicle modifications $500 and above, the package is submitted to the Vehicle Modification Project Manager for technical review. The package then goes to the Chief of Policy for casework/policy review. If the estimated amount is within the approval authority of the Unit Manager, then the Unit Manager should review the case record with particular emphasis on this information generally required in the client data package. The required components of the client data package are specific to the type of modification and are found in the applicable Client Data Package Checklist found on the VR intranet.

CONTRACT PACKAGE: This is a package of information prepared by the Unit Manager or the Purchasing Manager and sent to the vendor authorizing the vendor to proceed with the project. Included in this package are:

* The case service authorization (or purchase order if issued by the Purchasing Manager) signed by the Unit Manager and/or the Purchasing Manager if the accepted bid exceeds the maximum amount allowable for the Unit Manager to authorize);
* A copy of the bid from the selected vendor;
* A copy of the modification specifications; AND
* A cover letter authorizing the vendor to proceed with the project.

VENDOR SELECTION: The process, as defined by the Division of Purchase and Contract, is the same for all modification projects regardless of the cost and must be followed. The Counselor, along with assistance from the Rehabilitation Engineer, is responsible for initiating this process and must canvass the local area to assure all potential and interested vendors are offered the opportunity to bid on each project. Sufficient bids should be solicited to assure that a minimum of three (3) competitive bids are returned. Only those bids returned by the closing date will be considered valid. The vendor who submits the low bid that meets specifications within the deadline noted on the bid is generally selected to

complete the project. This process must be strictly followed unless otherwise approved by the Regional Director.

BID PROCESS: All bids should be neatly prepared on the contractor's stationary or the Division's bid form with the vendor's full name, address, and itemized costs. To be considered valid, the bid must be signed and dated by the vendor. Bids should identify each part of the project and have the cost of each along with the total cost clearly stated.

REHABILITATION ENGINEER: The Rehabilitation Engineer is responsible for developing specifications with drawings and sketches for all modification projects involving Division funds. Other responsibilities include recommending vendors, developing project cost estimates for the Division, and assisting the Purchasing Manager in developing and reviewing the bid specifications. An engineer is required to be present for delivery of all vehicle modifications.

VEHICLE: For the purposes of this policy, vehicle includes automobiles, trucks, and vans. Motorcycles, mopeds, and golf carts do not fit this definition. When modifying used vehicles, Counselors should be cognizant of the cost of the modifications versus the value of the vehicle.

DMV REVIEW: A review conducted by the Chief of Policy for the purpose of assessing the vehicle operator's driving history. Vehicle purchases, modifications, and insurance require this review. Individuals with poor driving records and infractions will not be provided assistance with vehicle modifications, vehicle purchases, or vehicle insurance.

Forms

FORM DVR-0196, REQUEST FOR VEHICLE MODIFICATIONThis form is intended to inform the client and vehicle owner of the specifications and proposed modifications, that the Division is not responsible for removal of the proposed modifications, that the Division may reclaim modifications if it is determined that they are no longer needed by the client, that the Division is not responsible for restoring the property to its original condition, and to fully indemnify the Division as a result of the modifications. If, during the review process, the originally recommended modifications are altered, then a new *Form DVR-0196* must be completed.

FORM DVR-0197, REQUEST FOR RESIDENCE MODIFICATION: The form which must be completed by the Counselor and signed by the property owner and client for all residence modifications involving Division funds regardless of the cost of the project. The purpose of this form is to assure that the client and property owner are fully aware of the specifications and proposed modifications. If, during the review process,

the originally recommended modifications are altered, a new *Form DVR-0197* must be completed with appropriate signatures.

FORM DVR-7001, VEHICLE INSPECTION SHEET: This form must be completed and signed by an ASE Certified mechanic when modifications to used vehicles are being considered. All used vehicles being considered for modifications must be evaluated with an emphasis on safety and "life expectancy" of the vehicle. Recommended repairs may be authorized by the Counselor while general maintenance and "upkeep" items must be supplied by the client.

2-10-1: Residence Modifications

Residence modifications may be considered when the goal of modifying the residence is to enhance the individual's independence in relation to community integration and/or employment.

Division Maximum Rates for Residence Modifications

Per Client

A limit of $12,000 total Division case expenditures per client per lifetime shall be placed on residence modification projects in general, with specific project limits based on the type of residence. Only Division case expenditures are considered when applying these limits; therefore, contributions from third parties toward these projects or project totals are not to be included in the totals when applying the limits. When it is estimated that the Division limit above will be exceeded, the case is to be handled as per the applicable tables below (See *Step 4* below).

Per Project

A limit of $12,000.00 per project shall be placed on modification projects when the residence is owned by the client or client's immediate family. If the cost per project is estimated to exceed $12,000, a bid packet, in addition to a *Residence Modification Client Data Packet* is to be submitted to the Chief of Policy for approval. The Purchasing Manager is responsible for bidding and purchasing residential modifications exceeding $12,000. A project, for purposes of this policy, shall be defined as the group of all planned modifications foreseen to occur at a residence necessary to enable an individual to obtain their IPIL goals.

Modifications to a mobile home owned by the client or the client's immediate family which is located on land owned by the client or client's immediate family, except for those situations where exterior modifications are not permanently affixed to a parcel of rented or leased land and is moveable with the mobile home, shall not exceed $8,500.00 per client per

project**.** Modifications to a mobile home not meeting the above requirements shall not exceed $5,500 per project.

Modifications on rented or leased residences shall not exceed $5,500.00 per project.

Exceptions to these amounts must be approved by the Chief of Policy and are based on the following criteria:

- cost of unforeseen structural damage needing repair
- total cost of residential modification projects over the life of the case
- the project presents a favorable benefit/cost ratio
- the counselor's assessment that the client will make use of the modifications for a reasonable period of time
- if adaptive equipment and related assistive technology and devices are necessary to accommodate the individual's degree of disability and to enable the individual to complete the rehabilitation program

Statewide budget code *RCC 1290* can be used for residence modifications for VR program clients. IL Counselors must use their individual case service budgets.

Residence Modification Process

1. Review and determine previous client expenditures for Residence Modifications.
2. The Counselor must consult with the Unit Manager/Facility Director regarding the feasibility of the project. If the project is supported by the Unit Manager/Facility Director, the Counselor must involve the rehabilitation engineer in discussion about the project.
3. The Rehabilitation Engineer must visit and evaluate the site to determine the feasibility of the project. The Rehabilitation Engineer will then develop the project specifications and provide a report to the Counselor along with an estimated cost of the project.
4. The charts below explain the Division's approval and purchasing process based on the cost of the project. For Residence Modifications not exceeding allowable limits (see table below) the project is bid out and awarded by the Unit Office.

Client/ Immediate Family-Owned Residence (Site Built)			
If Estimated Cumulative VR/IL Expenditures per case are:	**Current Project Estimate is:**	**Approval By:**	**Bid (or re-bid) and Purchased by:**
<$12,000	≤$12,000	UM or designate	UM or designate
>$12,000	≤$12,000	Chief of Policy	UM or designate

>$12,000	>$12,000	Chief of Policy	Purchasing Manager (PM)—Note: Must be Bid and Purchased by PM.

Client/Family Owned Residence (Mobile Home Permanently Placed on Client/Family Owned Property)			
If Estimated Cumulative VR/IL Expenditures per case are:	**Current Project Estimate is:**	**Approval By:**	**Bid (or re-bid) and Purchased by:**
<$12,000	≤$8,500	UM or designate	UM or designate
<$12,000	$8,501 - $12,000	Chief of Policy	UM or designate
>$12,000	>$12,000	Chief of Policy	Purchasing Manager—Note: Must be Bid and Purchased by PM.

Client/Family Owned Mobile Home on Rental Property, or Strictly Rental Property			
If Estimated Cumulative VR/IL Expenditures per case are:	**Current Project Estimate is:**	**Approval By:**	**Bid (or re-bid) and Purchased by:**
<$12,000	≤$5,500	UM/FD or designate	UM/FD or designate
<$12,000	$5,501 - $12,000	Chief of Policy	UM/FD or designate
>$12,000	>$12,000	Chief of Policy	Purchasing Manager—Note: Must be Bid and Purchased by PM.

5. The vendor will complete the project and send the invoice to the Rehabilitation Engineer.
6. The Rehabilitation Engineer will visit the work site to assure that all project specifications have been followed in a satisfactory manner. When the project is approved, the Rehabilitation Engineer will sign the contractor's invoice and forward it to the Counselor. If the project is deemed unacceptable, the rehabilitation engineer will consult with the Unit Manager/Facility Director, Counselor, client, and vendor to resolve the situation.

7. The Counselor will attach a copy of the contractor's invoice to the case service invoice, which must be signed by both the Unit Manager/Facility Director and Counselor, and submit it to Case Service Accounting for payment.

[10 NCAC 89C .0316; 34 CFR 364.4]

2-10-2: Vehicle Modifications

In order to assist an individual in increasing their independence or maintaining or obtaining employment, the Division may assist with modifications of the vehicle. Individuals for whom such modifications are considered must have been determined eligible for VR/IL services. All modifications are subject to the individual's financial need and comparable benefits. The rehabilitation engineer shall be involved in all modification projects involving Division funds. The engineer may be involved with developing specifications using drawings and sketches as well as developing project cost estimates for the Division. The Purchasing Manager is responsible for developing and reviewing the bid specifications. An engineer is required to be present for delivery of all vehicle modifications.

The IL program may assist with the modification of a participant/family-owned or leased-to-purchase vehicle in order to enhance the participant's ability to function independently in the family or to actively participate in the community. Modifications may be considered for participants enrolled in secondary school.

The VR program may assist with modifications to a client/family-owned or leased-to-purchase vehicle for employment purposes or to assist with commuting problems while the individual is enrolled in a college training program where there are no or limited on-campus living facilities or if transportation is required as part of the training curriculum. Modifications shall not be considered for clients enrolled in secondary school.

The Division will only contribute financially towards vehicle modifications that are recommended by the rehabilitation engineer. Prior to the Division's participation, a thorough analysis of the individual's transportation needs must be conducted and other options, such as public conveyance or conveyance by a family member or other support person, must be considered and used when available. This analysis shall be included as a part of the Client Data Package.

Proof of Insurance

The consumer must provide proof of collision and comprehensive insurance for the vehicle and adaptive equipment prior to the adaptive equipment being purchased. If the vehicle is involved in an accident, the Division considers insurance to be a comparable benefit in sponsoring repairs or replacements.

Maximum Rates for Vehicle Modifications

The IL program may support vehicle modification projects that are estimated to be equal to or less than $7000.00:

A. for vehicles that are newer than 10 years or have less than 120,000 miles; OR

B. that can be easily transferred to another vehicle if need be or can be installed in a vehicle not limited to the previous age/mile limit, provided the vehicle passes both the rehabilitation engineer's inspection and the DVR-7001 inspection with an estimated additional useful life of 5 years.

The Chief of Policy must approve any exception to the maximum limits stated above.

Vehicle Modification Process

Est. Cost	Steps
≤ 500.00	1. Approved by UM
	2. Engineer reviews, develops specifications, and estimates
	3. Bid process by counselor
	4. Vendor selection by counselor
	5. Contract package by the UM
	6. Rehabilitation engineer approves completed project
	7. Counselor forwards vendor invoice with case service for payment
> 500.00	1. UM/FD consult
	2. Engineer reviews, develops specifications, and estimates
	3. Submit to Vehicle Modification Project Manager for technical review of project. The Chief of Policy then reviews it for policy/casework compliance and final approval
	4. Approved by Chief of Policy
	5. Bid process by Purchasing Manager
	6. Vendor selection by Purchasing Manager
	7. Contract package by Purchasing Manager
	8. Rehabilitation engineer approves completed project
	9. Rehabilitation engineer initials vendor invoice and forwards to Counselor
	10. Counselor forwards vendor invoice with case service for payment

2-10-3: Worksite Modifications

The IL program may only sponsor worksite modifications when there is a joint VR/IL case and when VR funds are utilized. The goal of modifying the job or work site is the suitable placement of a client, including clients who are self-

employed, and the successful conclusion of a rehabilitation program by increasing job accessibility, reducing mental demand, reducing physical demand, alleviating physical distress, alleviating mental/emotional stress, increasing energy conservation, improving quality, or reducing dependency. Placement equipment is not included in this policy and should not be counted in calculating the cost of job and work site modifications. The employer and/or owner of the property to be modified must review the modification plans and understand the changes the Division is proposing. The client, the employer, and/or the property owner must also understand that the Division can remove certain Division-purchased free-standing equipment when it is no longer needed at the job site. The Division will not be responsible for expenses incurred for changes not needed to accommodate persons with disabilities. *Form DVR-0191, Request for Worksite Modification,* must be signed by the property owner to free the Division from responsibility of the expense of restoring any property or equipment to its previous condition if the client is no longer employed at that site.

Maximum Rates for Worksite Modifications

A limit of $7000.00 shall be placed on all worksite modification projects. Unit Managers shall approve and oversee the bidding and vendor selection process for projects less than, or equal to, $500.00, while projects estimated to be greater than $500.00 must be approved by the Chief of Policy. Exceptions to the maximum contribution are based on the degree of disability and the cost of modifications and adaptive equipment necessary to complete the rehabilitation program. Individuals whose disability necessitates extensive technological adaptations require more extensive solutions. Statewide budget code RCC 1290 can be used for work site modifications.

WORK SITE MODIFICATION PROCESS

Est. Cost	Steps
≤ 500.00	1. Approved by UM
	2. Engineer reviews, develops specifications and estimates
	3. Bid process by Counselor
	4. Vendor selection by Counselor
	5. Contract package by UM
	6. Rehabilitation Engineer approves completed project
	7. Rehabilitation Engineer initials vendor invoice and forwards to Counselor
	8. Counselor forwards vendor invoice with case service invoice for payment
> 500.00	1. UM consult
	2. Engineer reviews, develops specifications and estimates
	3. Submit to Chief of Policy for review and approval
	4. Bid Process by Purchasing Manager

	5. Vendor selection by Purchasing Manager
	6. Contract package by Purchasing Manager
	7. Rehabilitation Engineer approves completed project
	8. Rehabilitation Engineer initials vendor invoice and forwards to Counselor
	9. Counselor forwards vendor invoice with case service invoice for payment

[l0A NCAC 89C .0205 and .0206 (Financial Needs Test) and 10A NCAC 89C .0300 , Scope and Nature of Services; 10A NCAC 89C .0316; 34 CFR 364.4]

Section 2-11: Personal Assistance Services

CROSS REFERENCE: **Appendix Entry-Personal Assistance Definitions and Procedures**

Personal assistance is hands on assistance with two (2) or more major activities of daily living (ADL). The Division shall not sponsor chore worker or housekeeping services as a sole service. Housekeeping or chore worker services shall be secondary to the hands on ADL activities and shall not be the only assistance that is needed.

ADL tasks are basic daily living activities that must be performed to assure or support one's physical well-being. Examples of the major ADL activities include body/oral hygiene, bathing, toileting, dressing, grooming, eating, transferring, and moving about as needed in the environment.

Housekeeping and chore worker activities involve basic activities that help to provide a safe and healthy living environment and promote community inclusion. Examples include cleaning, laundry, preparing meals, shopping, bookwork, and transportation.

Workers that provide ADL and housekeeping/chore worker services do not require any state licensure or certifications.

2-11-1: Vocational Rehabilitation Program

Personal assistance services may be sponsored at any time during the rehabilitation process to enable clients to fully participate in the assessment for determining eligibility and vocational rehabilitation needs, planning, service provision, and employment. It is a support service which can only be provided in relation to and in support of another vocational rehabilitation service. Sponsorship of this service is not intended to supplant services traditionally provided by the client's family. Personal assistance services are not subject to

financial need, but comparable benefits must be utilized when available. Under no circumstance shall the Division sponsor co-pays for personal assistance if the client is utilizing Medicaid or another similar benefit to acquire personal assistance. Personal assistance can be provided by establishing the VR client as a household employer or by authorizing to Home Health agencies or medical service organizations. When home health care agencies are utilized, the Division shall authorize payment directly to the home health care vendor, and a concurrent case with IL is not opened. **The VR counselor cannot authorize greater than 28 hours per week for personal assistance. Requests to exceed 28 hours per week shall be submitted to the Unit Manager.**

Criteria

In order for a VR client to receive personal assistance services, the individual must be eligible for VR services and determined to be either SD or MSD based on a physical disability with functional limitations in the areas of self care and/or mobility. The individual must require personal assistance services (PAS) in support of one or more of the CORE VR services planned on the Individualized Plan for Employment (IPE).

Concurrent Records of Service

When the counselor and VR client elect to pursue personal assistance by establishing the client as a household employer, the client will have a dual VR/IL case with IL providing the personal assistance services for the individual. The funding for the PAS will come from VR case service funds. If other IL services are required in order to achieve the IL primary objective, then these services should be funded by IL, and IL policies should be applied. However, any services which are related to the achievement of the client's IPE goal should be funded by VR and provided according to VR policies.

Transition of Personal Assistance and Personal Assistance in a Post-Employment Plan

During the comprehensive assessment, the VR Counselor shall consider factors related to the transitioning of personal assistance services. In cases where personal assistance is needed to support training, the counselor shall discuss and document a client's stated needs related to transitions such as school breaks, completion of training, beginning a job search, and job placement. In cases where personal assistance is needed in support of job placement, the Counselor shall discuss and document any stated needs related to post-employment personal assistance services. This includes a discussion of comparable benefits, including the client's ability to private pay using the client's earned income. When referring a client to IL for coordination of personal assistance, the VR Counselor shall notify the IL counselor of the client's stated needs as related to transitions in personal assistance services so

that the IL Counselor may effectively consider the service as part of a plan for independent living. Communication and coordination shall continue throughout service provision regarding personal assistance transitions.

At the point in which the client has achieved all other requirements for a successful employment outcome other than the termination of personal assistance services, the VR Counselor shall coordinate with the IL Counselor to determine whether the client is likely to meet the IL program's financial eligibility to continue personal assistance. If it is unlikely that the individual will qualify for this or other comparable benefits, the VR Counselor may continue to refer the client to the IL program for personal assistance coordination to be paid for out of VR case service funds as part of a VR post-employment plan.

In concurrent records of service,
The VR counselor will:

1. Identify that personal assistance service may be needed for the individual to complete their Individualized Plan for Employment (IPE).
2. Contact the IL Office to staff the case with the IL counselor covering that geographical area where the individual will be receiving the personal assistance service.
3. Notify the client that the IL program will complete an Assessment of the Individual's Personal Assistance Needs and coordinate personal assistance services.
4. Grant full CATS access for the VR case to the appropriate IL staff and provide copies of the VR eligibility decision, SD/MSD documentation, supporting medical documentation, and information related to any transitions required for personal assistance services.
5. Upon the IL counselor's completion of the Assessment of the Individual's Personal Assistance Needs, update the IPE to indicate that the personal assistance service is coordinated by the IL program and is funded by VR. The IPE should include the statement "Personal assistance service that is funded by VR, will be terminated when the VR case is closed."

The IL counselor will:

1. Take an IL application
2. Complete IL Eligibility Decision using, to the extent possible, preliminary assessment data from the VR case file. The IL counselor will obtain from VR the:
   (a) VR Eligibility Decision

(b) SD/MSD documentation
(c) Supporting medical documentation
(d) DVR-0116

3. Complete an IPIL outlining the services. Minimum jointly agreed upon services on the IL plan should include:
   (a) Guidance and counseling provided by IL.
   (b) Number of personal assistance service hours and rate of pay with VR Funded as Comparable benefit.
   (c) Include the statement on the IPIL "Personal assistance service that is funded by VR, will be terminated when the VR case is closed."
4. Issue the authorization for personal assistance service on the state fiscal year **from VR case using RCC 1281 / CS code T27**. The R2 is maintained in the IL case file until the case is closed.
5. Enter the VR information into the "Client Data Entry Screen" using the VR icon. The IL staff will key in the VR number, VR caseload number, VR counselor code number, vendor number, client ID number, select the IL office code, and the RCC 1281 will be filled in automatically. This information and the CS code T27 will print onto the case service invoice. The case service invoice should be printed on green paper for VR and the IL counselor will sign the case service invoice.
6. Keep the IL case open for the duration of IL coordinated personal assistance services.
7. Maintain all fiscal information (R2, case service invoices, timesheets, receipts for paying personal assistant(s) and federal/state taxes) in the IL case file until the IL case is closed. At that time, a copy of this information will be provided to the VR counselor so that this information is maintained in the VR case, in keeping with the record retention schedule.

2-11-2: Independent Living Program

The Independent Living Rehabilitation Program (ILRP) provides a part-time personal assistance service for those individuals who meet the requirements described in this section. This service is subject to both the individual's financial eligibility and comparable benefits.

Personal assistance is to be a client -driven service. The counselor shall gather data relative to several aspects of personal assistance at the time of application and at closure, in order for the Division to assess the impact of this service.

Client Selection for Personal Assistance Service

Due to funding limitations for this service and the often large number of requests received, counselors shall prioritize applicants. Further, an evaluation of the basic personal assistance service needs of the referred

client (e.g., hours of assistance needed and availability of other resources including reviewing the other resource's assessment and plan of care) must be secured by the counselor prior to planning personal assistance on the IPIL. Those individuals targeted to receive personal assistance services (in order of priority) are:

1. Individuals currently living in an institution who require personal assistance as part of discharge plan
2. Individuals living independently who, if PAS is not provided, will be placed in an institution within the next 90 days
3. Individuals who need personal assistance to remain independent in the community but who are not in immediate danger of being institutionalized OR individuals who are employed and need personal assistance to maintain employment

Assessment of Individual's Personal Assistance Needs

Once an individual has been identified as a candidate for personal assistance services, the IL counselor shall obtain a personal assistance evaluation in order to determine the client's ability to participate in and benefit from personal assistance. When the individual has been served by CAP-DA, the Division of Aging and Adult Services, or the Division of Medical Assistance, existing records shall be obtained. If there are no existing evaluations of the individual's need for personal assistance, the counselor shall utilize a registered nurse, physical therapist, or occupational therapist to complete an evaluation. The age of the evaluation shall not exceed 12 months. This assessment shall be obtained or repeated annually. Data gathered by the evaluation should include information related to the following areas:

1. Medical
2. Housing
3. Functional Assessment
4. Social/psychological history
5. Community Resources
6. Community Accessibility
7. IL goals
8. Specific needs for personal assistance
9. Other resources available for personal assistance
10. Number of hours required
11. Availability of personal assistants meeting the applicant's expected qualifications
12. Personal assistance routine and schedule
13. Individual's management skills
14. Emergency back-up plans

Other specialty evaluations, such as psychological evaluations, may be secured when necessary, in order to better determine that the individual satisfies item 13 of the criteria above.

When the evaluation has been completed, a narrative of the results shall be prepared justifying the need for personal assistance services. The client's file shall be staffed with the Unit Manager or the Unit Manager's designee for approval of personal assistance services.

The maximum number of allowable hours for IL-sponsored personal assistance services shall be determined following a review of the recommendations of the personal assistance evaluation and IL staff, but shall not exceed forty (40) hours per week. Any changes to personal assistance hours as well as changes to an assistant's wage rate must also be approved by the Unit Manager. Approval requests shall briefly describe justification for a change in hours, justification for services in excess of twenty-eight (28) hours, or justification for the change in wage rate.

Selection Criteria

Individuals for whom personal assistance services are planned must:

- Be eighteen (18) years of age or older;
- Be intellectually and emotionally capable of directing and managing a personal assistant or capable of doing so after completion of personal assistance management training;
- Hire their personal assistant(s);
- Make payment to the personal assistant(s);
- File and pay Social Security and Medicare taxes (FICA), State and Federal unemployment taxes, or any other employment obligation(s) that is required of household employers including reporting new hires and garnishing employee wages, if required; and
- Sign *Form DVR-1021 Personal Assistance Services and Reimbursement Agreement*
- Explain *Form DVR-1022 Personal Assistant Understanding of Employer Obligation to Withhold Social Security and Medicare Taxes (FICA)* to each assistant hired and require that the assistant(s) sign this form.

Management Training

Personal assistance management training is provided to instruct clients in ways to develop an employer/employee relationship with the individual's personal assistant. Specific topics include identifying one's self-care needs, developing management skills, assertiveness training, recruiting personal assistants, interviewing techniques, hiring and firing, dealing with performance or salary issues, and completing DVRS forms.

Bi-Annual Evaluation and Client Contact

A bi-annual telephone contact and a bi-annual face-to-face visit will be made by IL staff in order to monitor the client's independent living status, review personal assistance documentation, and make suggestions or assist with situational changes, if needed. The telephone contact and face-to-face visit will be alternated throughout the calendar year such that the client receives contact each quarter either by phone or in person. During the quarter that the annual evaluation is conducted, this visit may take the place of the required bi-annual face-to-face visit. A quarterly face-to-face visit may be conducted if the counselor determines that more frequent visits are needed.

During the bi-annual face-to-face visit, the VR/IL client is required to make available to their IL counselor the personal assistance service checking account bank statements for the preceding six months. The IL counselor will review this information to ensure that the check numbers and amounts reflected on DVR-1022B, DVR-1019A, or DVR-1019A-W correspond with the check numbers and amounts on the bank statements.

The IL Counselor shall continue to explore comparable benefits for personal assistance during bi-annual evaluations and client contacts (e.g., CAP-DA, Division of Aging and Adult Services, Division of Medical Assistance). If, during the bi-annual evaluation, the Counselor and client identify comparable benefits for providing personal assistance, the Counselor shall assist the client in exploring these benefits. If the IL Counselor determines that the client is no longer able to manage the IL personal assistance service due to cognitive or mental decline, the IL Counselor must develop a transition plan for the client to begin utilizing another source of personal assistance services. This may include assisting the client in identifying other public programs for the client to contact. In cases where the client becomes too significantly disabled to manage the Division's personal assistance service, yet still requires this type of support, the IL Counselor may authorize time-limited personal assistance to be provided by a home health agency until the client can successfully transition to another public program.

Client as Employer

In the provision of personal assistance services, the IL client shall assume the role of a household employer. The client's personal assistant(s) will assume the role of employee. *Form DVR-1021 Personal Assistance Services and Reimbursement Agreement* outlines the client's responsibilities as employer. This form must be signed by the client annually, or when there is a change in the number of hours and/or the wage rate of the personal assistant(s). As a part of this agreement, the client must obtain state and federal household employer ID numbers within fourteen (14) days of being approved for the DVRS personal

assistance service. The client must then provide their counselor with a copy of their federal and state household employer ID numbers within forty-five (45) days of being approved. Failure to provide their counselor with a copy of their federal and state household employer ID numbers within forty-five (45) days shall result in a delay in processing reimbursement for personal assistant services.

The client is required to establish a separate checking account to be used only for the receipt and disbursement of personal assistance funds. Clients funded by IL shall complete and submit the *Payment Verification Form* as soon as possible, and no later than 14 days, to provide the Division with bank routing after the Division agrees on service provision.

As the employer of the personal assistant(s), the IL client controls the terms and conditions of the personal assistant's employment. The client is required to develop a job description of the duties that the personal assistant(s) will perform and to interview prospective personal assistant(s). The counselor may provide a sample Personal Needs Checklist for the client to use when recruiting personal assistants. If, upon interviewing, the client is unable to identify a personal assistant who meets all of the pre-defined qualifications, the client has the option to train an individual who closely meets the qualifications in those areas in which the individual is deficit. The client may also arrange for family members, or others whom are capable, to provide the training. The client's counselor will be available for questions that the client may have during their consideration of personal assistant applicants, but it is the client's responsibility to make the final decision about whom they hire as a personal assistant. The personal assistant(s) hired by the IL client:

- May reside in the same residence as the IL client
- Must be eighteen (18) years of age or older
- Do not require any state licensure or certification

The hourly wage rate for personal assistance services shall be negotiated between the IL counselor and the client prior to hiring the personal assistant. Only one hourly wage rate shall be allowed for an IL client, and that rate shall be used in paying all assistants. A client shall not be reimbursed at an hourly rate that exceeds the actual hourly expenditures for personal assistance services, and in no instance shall a client's hourly reimbursement rate exceed the current Medicaid rate for personal assistance services.

The IL client is not required to withhold federal and state income tax on their personal assistant(s). The IL client is responsible for advising the personal assistant(s) of the taxes that they are reporting and paying on their behalf and to answer their questions about wages, taxes, etc.

The IL client shall submit a request in writing to their counselor if they wish to request a change of hours or wage rate. A change of either hours or rate would be contingent upon the availability of Personal Assistance Service funds. The number of hours of personal assistance requested must be consistent with the client's personal assistance evaluation, and the portion being reimbursed by DVRS shall not exceed forty (40) hours per week.

The IL client may employ and pay personal assistant(s) for hours in addition to the number of hours and rate that DVRS agrees to reimburse the client. However, the client is fully responsible to pay for the additional hours and rate. The client cannot pay for the additional hours or rate using the personal assistance checking account. The client cannot include the additional hours and rate on *Form DVR-1019 Record of Personal Assistant Hours*, *Form DVR-1019A, Personal Assistance Services Receipt* or on *Form DVR-1019A-W, Personal Assistance Services Receipt-Weekly Payment*. Hours that a personal assistant does not work during the first week of the two-week pay period cannot be carried over to the second week of the pay period.

If the IL client employs more than one personal assistant, no two (2) personal assistants may assist with the client's personal care at the same time. Also, if another agency is providing personal assistance services to the client, the personal assistant(s) reimbursed by DVRS cannot be working at the same time as a personal assistant funded by the outside agency. DVRS shall not reimburse the IL client to pay for overtime if the personal assistant works more than forty (40) hours per week.

If the IL client employs more than two (2) personal assistants at any given time, the client is responsible for obtaining worker's compensation insurance. DVRS will not reimburse the VR/IL client for the worker's compensation insurance, and DVRS is not responsible for any penalties which would result if the client failed to obtain the required worker's compensation insurance.

The IL client shall not be reimbursed for personal assistance if the service was not provided. The client will not pay DVRS funds to their personal assistant(s) if the assistant(s) did not actually work. This includes times when the client may be in the hospital, otherwise away from home, or when personal assistance services are provided by another resource.

Personal Assistance by a Home Health Agency

In the rare situation when an IL client temporarily contracts with a home health agency for personal assistance services, the following requirements shall be met in order for Division funds to be used towards this assistance:

- Services shall be negotiated between the client and a vendor, with the counselor serving as a resource person or mediator.
- Authorizations shall not exceed Division maximums (Medicaid rate), and the vendor must agree not to charge fees in excess of this rate.
- Any vendor selected by the client shall be certified by the NC Health Services Regulation.
- Any vendor selected shall be responsible for all employer related expenses.
- For clients funded by IL, the Division shall make reimbursement payments to the client, who, in turn, is responsible for paying the vendor.
- The vendor shall agree to meet the client's personal assistance needs as defined by the client and the Division, and the client must be able to terminate the agreement without penalty when needs are not being met.

Authorizations and Invoices

Prior to authorizing personal assistance services, the IL client shall complete Management Training and shall hire the personal assistant(s). During Management Training, the client will be informed as to when and how to complete and submit the forms required for the authorization and invoicing of personal assistance. Specific instructions and deadlines for completing personal assistance forms are included in the Personal Assistance Procedures Manual in the Appendix. The PERSONAL ASSISTANCE DOCUMENTATION table below summarizes the paperwork necessary for authorization and invoicing. *Form DVR 1021, Personal Assistant Services and Reimbursement Agreement* should be completed prior to authorizing personal assistance services, annually thereafter and when there is a change in hours or wage rate. The *DVR 1022, Personal Assistant Understanding of Employer Obligation to Withhold Social Security and Medicare Taxes (FICA)*, should be completed and submitted within seven days of hiring the assistant or when there are changes in the wage rate. *DVR Form 1022A, Payment of Federal Household Employer Tax*, should be completed and submitted to the counselor within 21 days from hire and no later than March 1st of each year.

When the counselor authorizes for personal assistance services, the authorization shall cover several types of payments:

- Bi-weekly payment for personal assistant net pay
- Quarterly payment for SUTA taxes
- Annual payment for FUTA taxes
- Either annual or quarterly payments for FICA taxes (or, if at the end of the calendar year, the employee did not meet the FICA tax threshold, an annual payment to reimburse the assistant for the

employee share of FICA taxes).

Payments for personal assistance services funded by IL funds will be issued via direct deposit to the client's personal assistance checking account. Payments for personal assistance services funded by VR funds will be issued via paper check. Payments 1-4 above constitute the personal assistance *reimbursement rate* (i.e., total of all funds distributed to the IL client for the provision of personal assistance). Although the various types of personal assistance payments can be billed on the same date, it is required that net pay invoices be submitted separately from tax invoices. The client should be informed, however, that actual deposits for net pay and taxes may be lumped together.

Processing Payroll Invoices

The counselor shall authorize the personal assistance net pay for the anticipated period of the personal assistance not to exceed 12 months. All personal assistance invoicing should be completed using *DVR Form 1013A, Case Service Invoice for Personal Assistance Services: Client as Employer*. The net pay is invoiced every two weeks according to the Personal Assistance Services Calendar upon receipt of *DVR Form 1019, Record of Personal Assistant Hours*. If no hours are submitted on the *DVR-1019*, then the counselor does not invoice for the corresponding pay period. If the *DVR-1019* is received after the pay period invoicing deadline, the hours for that pay period are invoiced during the next pay period after the *DVR-1019* is received. DVRS staff is not allowed to process Form *DVR-1019* if it is filled out or signed prior to work being completed or if the information provided is incorrect. The client is required to complete and submit *Form DVR 1019A, Personal Assistant Services Receipt*, or *Form DVR 1019A-W, Personal Assistance Services Receipt-Weekly Payment*, to indicate that the client has received the net pay deposit from the Division and that the client has, in turn, issued payment to the personal assistant(s). No further payments may be issued until either the *DVR 1019A* or *1019A-W* is received.

Processing Tax Invoices

The counselor shall authorize SUTA quarterly and FUTA annually. The counselor shall authorize personal assistance employee *FICA taxes*, if applicable, according to the client's reimbursement schedule reported on *DVR Form 1022A, Payment of Federal Household Employer Tax*, (either quarterly or annually). The specific due dates for invoicing all taxes are available on the *Personal Assistance Service Tax Payment Schedule* which is provided at the beginning of each year by the IL Program Specialist.

The client is required to complete and submit *Form DVR 1022B, NC Payment of Federal/State Household Employer Taxes*, each time the client makes a payment for state or federal taxes (FUTA, SUTA, or FICA). The Division is not responsible for penalties incurred as a result of the client incorrectly determining the FICA tax payment schedule, the client making late payments, or the client underpaying required employer taxes.

The Division shall begin invoicing payments for SUTA taxes upon the client's first qualifying quarter. Once there is a qualifying quarter, the Division shall invoice SUTA taxes for all quarters which precede the qualifying quarter in the same calendar year. Likewise, the Division shall invoice SUTA taxes for all quarters following the qualifying quarter for an entire calendar year, even if the gross wages during these quarters is less than $1000. If the client continues for one year without meeting the SUTA quarterly threshold for wages paid, the client shall request an exemption from this tax in writing to the NC Employment Security Commission by January 15th. The client must provide the Division with a copy of this request and the response from ESC by January 22nd. The Division will invoice the SUTA tax for the qualifying quarter until the Division receives the ESC's response indicating that the SUTA tax has been waived.

The federal government prescribes a threshold at which an employee is responsible for paying FICA taxes. In instances in which a personal assistant does not accumulate enough in net pay to meet this threshold, the IL client will be responsible for reimbursing the employee's share of FICA which was withheld. In these cases, the client is required to complete and submit *Form DVR 1019B, Employee's Share of FICA Tax*, to indicate that the client has received the personal assistant's share of FICA tax in a deposit from the Division, and that the client has, in turn, issued payment to the personal assistant(s) to reimburse for the taxes which were unnecessarily withheld.

In accordance with IRS Publication 926 and ESC Publication 524, clients are not required to pay FICA, FUTA and SUTA taxes when employing a spouse, child under age 21, or a parent.

PERSONAL ASSISTANCE DOCUMENTATION*

Form Name	Person(s) Completing	Person(s) Reviewing	Form Due
DVR-1021 Personal Assistant Services and Reimbursement Agreement	Client	Counselor	After completion of Management Training, annually, and when a change in hours or wage rate occurs
Payment Verification Form	Client	Counselor DVRS Fiscal Services	14 days after hiring of 1st asst or when changes to bank account info
DVR-1022 Personal Assistant Understanding of Employer Obligation to Withhold Social Security and Medicare Taxes (FICA)	Personal Assistant Client	Counselor	Within seven (7) days of hire or if hourly rate changes
Copy of *IRS Form SS-4* with Federal Employer ID number	Client	Counselor	Within 45 days of approval for service
Copy of ESC letter with State Employer ID number and tax rate	Client	Counselor	Within 45 days of the approval for service
DVR-1022A Payment of Federal Household Employer Tax	Client	Counselor	Within 21 days of hire, and no later than March 1st of each year
DVR-1019 Record of Personal Assistant Hours	Client	Counselor	Each pay period due date
DVR-1019A Personal Assistant Services Receipt	Personal Assistant Client	Counselor	14 days after receipt of payment
DVR 1019A-W Personal Assistant Services Receipt-Weekly Payment	Personal Assistant Client	Counselor	14 days after receipt of payment
DVR 1019A-G Personal Assistant Services Receipt and Garnish Wages for Child Support and Income Tax			
DVR 1019B Employee's Share of FICA Tax	Personal Assistant (if not spouse, parent, child < 21) Client	Counselor	14 days after receipt of payment
DVR 1022B NC Payment of Federal/State Household Employer Taxes	Client	Counselor	7 days after paying state/federal household employer taxes
Copy of *NCUI-104* with SUTA Tax Rate	Client	Counselor	December 15th each year
Letter to ESC to Exempt from SUTA (if applicable)	Client	Counselor	January 22 of each year
Approval from ESC for SUTA Exemption (if applicable)	ESC Client	Counselor	By seven (7) days of receipt from ESC

*** If the information outlined in the documentation table is not provided to the Counselor within the specified timeframe, the Division shall delay reimbursement.**

2-11-3: Suspension and Termination from Personal Assistance Services

All incidences of Client non-compliance with personal assistance policies shall be documented in the case record.

Individuals shall be suspended from receiving personal assistance for the following reasons:

A. Evidence of misuse of funds and/or use of funds for purposes other than personal assistance. Examples of misuse include not paying the assistant(s), not paying the federal/state mandated employer taxes, falsifying *Form DVR-1019, Record of Personal Assistant Hours*, misrepresenting personal assistance needs, or paying other bills with these funds;
B. Failure to have a checking account to be used only for personal assistance transactions, making transactions in cash, or not keeping copies of personal assistance records;
C. Failure to cooperate with program staff in efforts to implement policy and procedures pertaining to this service; AND
D. Refusal to sign or conform to the *Form DVR-1021, Personal Assistance Services and Reimbursement Agreement*.

Upon suspension, the Counselor shall contact the IL Program Specialist who will collaborate with the Chief of Policy to identify strategies to be included in a corrective plan for the particular incident of non-compliance. The Counselor shall partner with the client to develop the steps and timeframes required to be included in the corrective action plan. The corrective action plan shall be documented in the case record. The Division shall not reimburse the client for any personal assistance services provided during the period of suspension. The Counselor shall document the progress of the client in completing the corrective action plan in the case record. The Division shall resume service provision upon completion of the corrective action plan **within** the specified timeframe.

Individuals shall be terminated from receiving personal assistance for any of the following reasons:

- Financial gains to the point that the client can pay the full cost of personal assistance needs as documented by *Form DVR-0116, Financial Statement*
- Significant change in the disabling condition, as determined by the personal assistance evaluation, which eliminates the need for this service
- Completion of the Individualized Plan for Independent Living (IPIL), unless personal assistance is negotiated as an IL post-outcome service
- Identification of a comparable benefit (e.g., CAP-DA, Medicaid, Division of Aging) for this service in a manner compatible with the IL goal

- Relocation out-of-state or IL office service area unless approved by the Independent Living Rehabilitation Program Coordinator and DVR Chief of Policy
- Death or incapacitation that requires institutionalization
- Insufficient case service funds
- Failure to complete the corrective action plan in the specified timeframe
- Continued and repeated incidences of noncompliance that have resulted in two (2) or more suspensions within a two (2) year period of time

The suspension and termination decision must be made in partnership with the client. In cases of death or institutionalization when no executor, Power of Attorney, or guardian exists, the Counselor shall contact the IL Program Specialist, who in consultation with the Chief of Policy, can advise on final payment procedures. Should the client disagree with the Division's decision to suspend or terminate personal assistance services due to a breach in the personal assistance agreement, then the counselor must inform the client of the Division's administrative review and appeals process. Record of service documentation is required when personal assistance is suspended or terminated.

[10A NCAC 89C .0316]

Section 2-12: Physical Restoration

CROSS REFERENCE: **Interim Policy and Procedure Directive #04-2007, Physical Restoration and Physical Conditions**
Interim Policy and Procedure Directive #05-2007, Secondary Restoration Issues Accompanying a Chronic Impairment
Section 2-2-1 Core Vocational Rehabilitation Services

Physical restoration services are subject to the individual's financial need and comparable benefits. The IL Counselor must seek and utilize all comparable benefits prior to the provision of Physical Restoration Services.(Reference 3:10:3 Comparable Benefits) Such services may be provided as part of the Independent Living Plan to increase independence and enhance quality of life.

2-12-1: Chiropractic Services

The Division may utilize the services of any legally licensed doctor of chiropractic. This service is subject to financial need and comparable benefits. The following conditions must exist:

A. The client has signs or symptoms that are considered by a chiropractic physician to be related to spinal subluxation, and are not shown in the general or special examination to be due to other causes;

B. The client chooses the services of a chiropractic physician for spinal subluxation and/or spinal manipulation; AND

C There are no contraindications to spinal manipulations imposed by disorders other than spinal subluxation.

Chiropractic physicians may not be utilized during the assessment to determine eligibility and vocational rehabilitation needs.

[RSA-PRG-77-5; PL 92-603, Section 275 (Medicaid); G.S. 90-143 and 157.1; NCAC 20C Section .0303; 20D Section .0302]

2-12-2: Hearing Aids

Hearing aids may be sponsored for those individuals who meet the eligibility criteria listed in the Hearing Disabilities section of the Appendix and who require such devices for IL program purposes. A hearing aid may be purchased for a primary or secondary disability if the hearing loss meets the criteria for a hearing disability (See Appendix – Hearing Disabilities).

The Division will utilize vendors who provide a full range of services including servicing and loaner aids. Physicians who meet this requirement may provide ear, nose and throat (ENT) examinations, hearing evaluations, hearing aid evaluations and may dispense hearing aids (see Volume V for rates). Such services are subject to the client's financial need and comparable benefits, when available. (See 2-3-7 Telecommunicative Devices – Comparable Benefits).

In order to purchase a hearing aid, the counselor will authorize to an otologist and audiologist licensed to practice in this State for an ear, nose, and throat (ENT) exam, hearing evaluation, and a hearing aid evaluation. Medical clearance for fitting of an aid must be obtained from a physician skilled in diseases of the ear (ENT exam). The Division can not accept a waiver for medical clearance from an audiologist, a physician's assistant, a hearing aid dealer, or a family member.

The Division may purchase any kind of hearing aid (behind the ear, in the ear, programmable, or digital) recommended by a licensed audiologist or Board Certified Hearing Aid Specialist. The user's hearing aid should be equipped with a telecoil switch (T-coil switch). The 'T-switch" functions like an antenna, picking up the electromagnetic energy and transferring it to the hearing aid which converts it into sound. With a "T-switch", the client will be able to utilize additional assistive technology devices and have access to the telephone. (See Volume V – Hearing Aid Fees)

Purchase of a hearing aid is not subject to equipment procedures and limits as outlined under Section 2-3-9.

Clients are expected to follow the manufacturer's directions in using and maintaining a hearing aid. The client is responsible for safe storage of the hearing aid when it is not in use and attention to the safe handling of the device. Replacement hearing aids will **not** be purchased due to negligence that results in damage or loss.

A hearing aid can be repaired if feasible and cost effective, and the needed repair is not due to negligence. A replacement hearing aid may be purchased when an individual's current hearing aid is not sufficient to meet their needs due to a rapidly progressive hearing loss (See Appendix – Hearing Disabilities and Section 2-3-7 Telecommunicative Devices – Comparable Benefits).

Rehabilitation Counselors may also approve sponsorship of a replacement hearing aid if the client meets **two or more** of the following criteria:

A. The hearing aid is four years or older and has been properly maintained by the consumer;
B. The client has been accepted for the purchase of one hearing aid through the Equipment Distribution Services Hearing Aid program;
C. The client has been denied acceptance into the Equipment Distribution Services Hearing Aid program (letter must be put in the client's file);
D. The client is working and needs a hearing aid to maintain employment (a letter from the supervisor/employer is recommended for establishing the need);
E. The client has a documented rapidly progressive hearing loss (see Appendix – Hearing Disabilities).

For exceptions to this policy or extenuating circumstances, please contact the Chief of Policy or the Program Specialist for Deafness and Communicative Disorders.

2-12-3: Orthotics

Orthotic devices may be sponsored for individuals who require such services in order to complete the rehabilitation program. A prescription accompanied by a written evaluation that includes the need and the estimated life expectancy of the recommended device from the appropriate medical specialist is required prior to approval. Purchases and repairs are subject to the rates maintained in Volume V. Exceptions to these rates must be approved by the Chief of Policy.

A replacement orthosis may be purchased when repairs to the existing orthosis are not feasible or cost effective based on the written documentation obtained from the appropriate medical specialist indicating the cost of repairs and life expectancy in relation to the cost of new device by the IL Counselor. The IL Counselor should be aware of the cost of a new device in relation to the repair. These services are subject to financial need and comparable benefits.

[34 CFR 364.4;10A NCAC 89C .0303]

2-12-4: Prosthetics

Prosthetic devices may be purchased for individuals who require such services in order to complete the rehabilitation program. Purchases and repairs are subject to the rates maintained in Volume V. Exceptions to these rates must be approved by the Chief of Policy. A prescription accompanied by a written evaluation that includes the need and the estimated life expectancy of the recommended device from the appropriate medical specialist is required prior to approval. Outpatient and inpatient (with documented medical need) gait training may be provided.

Replacement prosthesis may be purchased when repairs to the existing prosthesis are not feasible or cost effective. The IL Counselor should be aware of the cost of a new device in relation to the repair. Replacements, as with initial devices, must be prescribed by an appropriate medical specialist. Repairs may be recommended and prescribed by a prosthetist.

PREPARATORY PROSTHESIS - Preparatory (also known as temporary) prosthesis may initially be purchased if prescribed and the permanent prosthesis purchased when the residual limb requires 15 or more plies of stump socks or, in rare instances, if shrinkage has plateaued at less than 15 ply after donning of the preparatory limb. In order to justify the purchase of a preparatory limb, the Counselor must ascertain through the attending physicians notes that, despite proper wrapping, the client is unlikely to achieve a residual limb of proper size and shape to avoid stump shrinkage so great as to require 15 or more plies of stump socks within a year of initial fitting. After the initial use of the preparatory limb, the prosthetist should use components from it as feasible in the manufacture of the permanent prosthesis.

These services are subject to financial need and comparable benefits.

[34 CFR 364.4; 10A NCAC 89C .0303]

Section 2-13: Recreational and Social Services

CROSS REFERENCE: **Subsection 2-3-4, Recreation Equipment**

2-13-1: Independent Living Program

Recreational Therapy services assist consumers to develop and use leisure in ways that enhance health, functional abilities, community reintegration, independence and overall quality of life. These services may be provided to consumers being served by offices to which a Recreation Therapist is assigned.

Upon referral by the IL Counselor, the Consumer should be evaluated for specific therapeutic recreational activities using the Recreational Therapy Assessment tool. Services are not subject to financial need include but are not limited to, facilitation of peer interaction; community navigation and leisure skills training, when provided directly by Division Staff. Services subject to financial need include but are not limited to adaptive equipment, sponsorship of initial fitness memberships and leisure activity classes.

[34 CFR 364.4]

2-13-2: Vocational Rehabilitation Program

Recreational services and therapy may be sponsored to the degree necessary to complete the rehabilitation program. Such services may be authorized to public or private establishments once vendorship is established.

Section 2-14: Rehabilitation Engineering

CROSS REFERENCE: **Subsection 2-2-1, Core Rehabilitation Services**
Section 2-9, Driver Evaluation and Training

Handbook: **Vehicle Modification Guidelines (intranet)**
Counselor's Driving Evaluation and Training Process (intranet)
Vehicle Modification Client Data Package Checklist (intranet)
Home Modification Client Data Package Checklist (intranet)

The term "rehabilitation engineering" means ". . . the systematic application of technologies, engineering methodologies or scientific principles to meet the needs of and address the barriers confronted by individuals with disabilities in areas which include rehabilitation, education, employment, transportation, independent living and recreation." Applicants and clients who are in need of and can benefit from rehabilitation engineering services and devices should be referred to the Rehabilitation Engineer. This includes services and devices which can supplement and enhance individual functions such as adapted computer access, augmentative communication, special seating and mobility, vehicle modifications, and services which can have an impact on the environment, such as accessibility, job re-design, work site modification and residence modification. The IL program may provide support for those technologies described above, or the technologies may be coordinated through joint VR and IL cases. When VR funds are being utilized for devices, equipment, and modifications, VR policy prevails. A rehabilitation engineering evaluation is not subject to an individual's financial need; however, devices, equipment and modifications recommended by

the engineer are subject to financial need. Rehabilitation engineering services can be provided without consideration of comparable benefits. However, where rehabilitation engineering services are readily available to the individual from other sources, they should be used.

[34 CFR 361.5; 34 CFR 364.4; 10A NCAC 89C .0315]

Section 2-15: Services to Family Members

Any rehabilitation service may be provided to a member of the client's immediate family if the service is required in the client's rehabilitation program, is essential to the success of the rehabilitation program and is not readily available through other agencies or resources. Such services are subject to financial need and comparable benefits as if the service was being provided to the client.

[34 CFR 361.42; NCAC 20C, Section .0307; 34 CFR 364.4]

Section 2-16: Transportation

CROSS REFERENCE: **Interim Policy and Procedure Directive #01-2008,**
Revision to Rate for Sponsorship of Private
Mileage

These services include the provision of or arranging for transportation. Transportation may be for the provision of assessment services or services leading to the accomplishment of VR/IL program goals. Public and private transportation services may be provided. Also included is payment for escorts, personal care providers or guides. Transportation services are subject to both financial need and comparable benefits unless transportation is required in conjunction with an assessment service. The mode of transportation should depend upon the circumstances of the individual, the availability and appropriateness of the transportation system, and upon fiscal considerations. The client or client's family should be used to provide transportation whenever possible without cost to the Division. The agency maximum (see Vol.V) should not be exceeded without first receiving approval from the Chief of Policy.

[34 CFR 361.42 (a)(6); 34 CFR 364.4; NCAC 20C, Section .0306]

2-16-1: Public Conveyance

Sponsorship of public conveyance may be sponsored at the rate charged by the vendor. This includes tickets for buses, trains, and other means of public transportation. Taxis may also be used.

2-16-2: Private Conveyance

When a private vehicle is used for transportation, the current IRS mileage rate will be authorized.

2-16-3: Personal Care Assistants and Escorts

Assistant or escort services will usually only be authorized for a client who is significantly disabled. The salary or fee is considered to be a related expense to the transportation of the individual. When assistant or escort services are obtained at no cost to the Division, travel costs and subsistence of the assistant/escort may be sponsored not to exceed State per diem rates. A family member should not be paid for services normally expected of a family member; however, if acting as an assistant or escort causes undue hardship to the family member, reasonable reimbursement may be paid. Authorizations must be issued to the client with the client paying the assistant/escort.

2-16-4: Permanent Relocation and Moving Expenses

Financial assistance for the permanent relocation of a client, or a client and family, may be provided when a move is necessary in order to support the client in transitioning to a primary residence. This assistance may be provided when the primary IL objective is deinstitutionalization or in situations where the individual is moving from a non-accessible residence into an accessible residence to support prevention of institutionalization or community integration. Included in this category are expenses for deposits and other relocation expenses. The Counselor should obtain three competitive bids for total moving costs and submit them to the Unit Manager for approval. The low bid should be accepted.

Section 2-17 Vehicles

2-17-1: Vehicle Purchases

CROSS REFERENCE **Subsection 2-10-2: Vehicle Modifications**

If the client elects to purchase a vehicle to be modified by the Division, the IL Program may contribute to the cost of the vehicle modifications at the maximums set for the IL Program. The client should only purchase vehicles recommended by the rehabilitation engineer based on the modification requirements of the individual. The Division is not responsible for costs incurred by the client if the rehabilitation engineer was not involved in recommending the vehicle purchased by the client.

[10 NCAC 20C .0316(d); Eff. 2/1/96]

2-17-2: Vehicle Repairs

Vehicle repairs may be authorized in order to assist a client in maintaining independence. Three bids should be solicited with the low bid being accepted. Repairs exceeding three hundred fifty dollars ($350.00) will be approved by the Unit Manager. When authorizing repairs, Counselors should be cognizant of the estimated value of the vehicle versus the cost of the repairs. General "upkeep" items should not be authorized. This service is subject to the individual's financial need and comparable benefits.

[34 CFR 364.4]

CHAPTER THREE: PRELIMINARY ASSESSMENT

The IL program will conduct a preliminary assessment in order to make a determination of eligibility. The IL Preliminary Assessment is necessary to determine whether an individual is eligible for services and to assign the priority for services.

Section 3-1: Timelines for Eligibility Determination

A determination regarding eligibility must be made within a reasonable period of time, not to exceed sixty days from the date the individual submitted an application for services unless exceptional and unforeseen circumstances beyond the control of the Division prevent a determination within sixty (60) days, and the Division and the individual agree to a specific extension of time. In such cases, an *Agreement to Extend Eligibility Decision (Form DVR-0505)* must be completed prior to sixty (60) days from the date of application. The original must be sent to the individual with a copy maintained in the record of service. The exceptional and unforeseen circumstances beyond the control of the Division along with the specific and agreed upon length of the extension must be documented. If a decision regarding eligibility is not made within the agreed upon timeline, then another *DVR-0505* must be issued to the individual. If the applicant refuses to agree to extend the eligibility decision and the data is not available to make the eligibility determination, the application process should be discontinued.

[The 1998 Amendments to the Rehabilitation Act of 1973 Sec. 102 (6)(A)(B); 34 CFR 365.30, 365.31; *Eff.8-7-98]*

Section 3-2: Use of Existing Information

Existing medical documentation or other specialist data shall be used for determining eligibility and rehabilitation needs. Counselor discretion is required to determine whether existing information is relevant and sufficient to determine eligibility for services.

If the existing data is not sufficient to describe the current functioning of the individual, then additional assessments must be obtained. The information must be sufficient to document the existence of a <u>significant</u> disability. Second opinions may be secured when a question arises regarding a diagnosis or treatment plan. In addition to medical data, counselor observations, school records, information provided by the applicant or the applicant's family, information used by the Social Security Administration, and determinations made by officials of other agencies may be used to identify limitations to independent living.

[State Plan-Section 7; 1992 Amendments to the Rehabilitation Act of 1973: Section 7(22)(A)(I)(I) and(ii); Section 102(a)(2) and (3); 34 CFR 361.42(c)(1)(2); 34 CFR 364.4z; Eff. 2-11-97]

Section 3-3: IL Case Status Codes and Definitions

For reporting purposes, the following case status codes will be used.

52 Applicant
58 Outcome from applicant status
60 Eligibility determined and plan development
61 IPIL implemented with a major objective of deinstitutionalization
62 IPIL implemented with a major objective of preventing institutionalization
64 IPIL implemented with a major objective of community integration
65 IPIL implemented with a major objective of PAS to maintain employment
66 IPIL implemented with a major objective of improving vocational potential with joint involvement with VR
76 Outcome after IPIL successfully completed
78 Outcome for other reasons after IPIL signed by client
80 Outcome for other reasons after eligibility determination, but prior to client signature on IPIL
82 Post closure services
84 Termination from post closure services

[34 CFR 364.51(a)(2) and 364.52]

Section 3-4: Referral and Application Process

CROSS REFERENCE: **Appendix Entry-Referral Script**

3-4-1: Availability for Services

In order to become an applicant for services or continue in services, the individual must be available to participate in necessary assessments for purposes of determining eligibility, rehabilitation needs and services. When a criminal records check indicates that the individual is a fugitive from justice (i.e. criminal background check contains instructions to contact law enforcement authorities immediately), the individual will not be considered available for services. Individuals in the following circumstances may not be considered available for participation in services:

- Have current charges with pending court dates or sentencing that would prevent the individual from participating in a program of vocational rehabilitation services (these situations must be staffed with the Unit Manager)
- Cannot/or are unwilling to attend appointments and evaluations

- Are unwilling to participate in essential disability related treatment that will enable an individual to benefit from Division services in terms of an independent living outcome

As a division of North Carolina state government, Vocational Rehabilitation is required to comply with any orders on file with the NC Departments of Justice and/or Departments of Correction for reporting individuals having outstanding warrants to the appropriate authorities.

[The Final Regulations to the 1998 Amendments of the Rehabilitation Act, 34 CFR Part 361, Sec. 361.41 (b) (C) (iii)] [NC General Statutes 14-267 and 14-259]

3-4-2: Referrals

Referrals may be made by any individual, agency, professional, relative or friend; or individuals may self-refer. Once an individual states a desire to apply for IL services, the individual must be provided with sufficient information to aid the individual's decision on further pursuit of services. This will include informing the individual that the Division conducts criminal background checks on all new referrals, including those who are minors. Upon completion of the criminal background check and documentation of other necessary referral data, the individual may be scheduled for a group orientation session. A referral form is completed utilizing the form available for Independent Living in CATS and WORD templates. Upon completion of the referral process, the individual may be scheduled for an appointment for purposes of taking an IL application. The following information will be documented on the referral form:

- Name
- Date of referral
- Address
- Date of birth
- Telephone number
- Stated impairment
- Stated Independent Living needs
- Referral source
- Directions to residence
- Completion of Criminal Background Check

Circumstances that result in a delay in the application process must be documented on the referral form for individuals who do not complete an application or in the comment section of the completed application. The date of referral must be entered into the database when the application date is entered.

Counselors will work closely with referral sources to establish criteria for appropriate referrals. It is also the counselor's responsibility to educate the referral source that the individual must consent to a referral to IL to be considered a referral. Individuals who have been referred as a part of a large list

of potential referrals will not be considered an official referral. If an individual indicates interest in applying for IL services after they have been contacted by a counselor or other designated staff, the application process must be initiated in an expeditious manner. Independent Living referrals must be initiated as soon as possible after the referral is made based on the priorities for services listed in subsection 3-7.

3-4-3: Timeliness of the Application Process

In order to assure that individuals with disabilities receive services in a timely and equitable manner, the Division shall initiate the application process as soon as possible for each referral. Independent Living must initiate contact based on the priority categories as listed in Section 3-7. Options for initiating the application process are as follows:

- Scheduling an individual intake and counseling session in the office
- Scheduling an individual intake and counseling session at the individual's residence at the time of referral
- Providing a referral packet to an individual who comes to the office and requests services
- A documented telephone call explaining IL services followed by mailing an application packet for the individual to return
- A letter or email with an application and information packet included

3-4-4: Procedures to Enter Applicant Status

The Division must inform each individual of the application requirements and identify the information that must be gathered to process the application. Referral packets mailed or given to the individual to complete must minimally include the following information:

- A cover letter explaining application requirements and advising the individual that their provision of existing information could assist with making a more timely eligibility determination.
- An application for services
- Information regarding client rights, appeals process and CAP
- Information Release Forms
- An explanation of the income verification process and required documents
- Requirement for a Social Security number
- Parent consent form if the individual is under 18

The preliminary assessment begins at the time of application for Division services and terminates at the time an eligibility decision is made. An individual is officially an applicant once the application form is appropriately completed and signed by the individual and/or, as appropriate, the individual's parent, guardian, advocate, or representative. Individuals who are under age eighteen and are not legally emancipated minors cannot apply for services until the counselor has received signed parental permission. Guardianship issues also must be considered. If an applicant does not speak English or understand verbal or

written information or if he or she communicates by sign language, the counselor must arrange for the most appropriate method of communication. Each applicant must be given a copy of the Client Assistance Program brochure. All required signatures must be obtained and maintained on a paper copy of the application in the case record.

3-4-5: Procedures to Exit Applicant Status

To exit the applicant process, the individual's record of service must:

A. Be closed for reasons other than ineligibility;
B. Be closed due to ineligibility; OR
C. Be determined eligible for rehabilitation services.

[1998 Amendments to the Rehabilitation Act of 1973]

Section 3-5: Determination of Impairments

3-5-1: Primary and Secondary Impairments

The primary impairment is the major disabling condition that is most responsible for the client's loss of functional independence. The applicant determined eligible for the Independent Living Rehabilitation Program must have a major disability code regarded as significant. A secondary impairment is any other disabling condition that contributes to, but is not the major source of, the individual's loss of functional independence. A secondary disability may, or may not be, a significant disability.

3-5-2: Physical Conditions

CROSS REFERENCE: **Interim Policy and Procedure Directive #04-2007, Physical Restoration and Physical Conditions**

Physical impairments must be diagnosed by the appropriate medical specialist and should be significant and chronic in nature. "Chronic" would refer to those conditions that are of long duration. "Acute" conditions are generally of short duration, of sudden onset, and should not present residual problems following treatment.

3-5-3: Psychological/Psychiatric Conditions

CROSS REFERENCE: **Appendix Entry-Learning Disability**
Appendix Entry-Intellectual Disability
Appendix Entry-Attention Deficit Disorder
Appendix Entry-Borderline Intellectual

Functioning
Appendix Entry-Substance Abuse

Evaluation and diagnosis by the appropriate specialist is required to establish the existence of a mental, emotional, or substance abuse impairment.* Appropriate specialists include:

Attention Deficit Disorder**

- Psychologist
- Licensed Psychological Associate
- Psychiatrist
- Neuropsychologist
- Neuropsychiatrist
- Neurologist
- Pediatrician

Autism/Pervasive Developmental Disorder

- Psychologist
- Licensed Psychological Associate
- Neuropsychologist
- School Psychologist (w/copy of IEP Team Report)
- Neurologist
- Neuropsychiatrist
- Pediatrician
- Borderline Intellectual Functioning**
- Licensed Psychological Associate
- Psychologist

Intellectual Disability, Learning Disability**

- School Psychologist (w/copy of IEP Team Report)
- Psychologist
- Licensed Psychological Associate

Other Mental Health Disorders

- Licensed Professional Counselor
- Licensed Clinical Addictions Specialist
- Licensed Marriage and Family Therapist
- Licensed Clinical Social Worker
- Licensed Psychological Associate
- Psychologist
- Psychiatrist
- Physician associated with Treatment Facility
- ASAM (American Society of Addiction Medicine) Certified Physician

Substance Abuse**

- Psychologist
- Psychiatrist

- Physician associated with a treatment facility
- ASAM (American Society of Addiction Medicine) certified physician
- Licensed Clinical Addictions Specialist
- Licensed Psychological Associate
- Certified Clinical Supervisor (CCS)

***Division staff having any of the above credentials are prohibited from diagnosing and providing treatment to individuals served by the Division of Vocational Rehabilitation Services. For questions about secondary employment contact the Human Resources Section of NC DVR.**

****Refer to the corresponding entry in the appendix for further documentation requirements for establishing the impairment and impediments.**

The condition must be chronic and current. Some individuals with mental health impairments may require evaluation by more than one specialist depending on the complexity of their impairment (e.g. a person with schizophrenia diagnosed by one of the nonmedical specialists may need referral to a psychiatrist for medical management). Counselor discretion is imperative in determining whether existing assessments are sufficient in describing the nature and severity of the individual's impairment. As always, if existing assessments are not sufficiently comprehensive to describe the individual's impairment and current functioning, additional assessments may be obtained.

If the individual falls within a target population group for publicly funded mental health services, the Counselor should use these resources for diagnostic and treatment purposes as long as access to and utilization of these services do not present substantial delays in or difficulty with accessing VR services.

Diagnoses noted as being "by history" are not accepted due to lack of current impediments to employment. Diagnoses with the qualifier "in full sustained remission" should be assessed on an individual case basis and may or may not present current impediments to employment.

For those individuals in school, intellectual disability, learning disabilities and autism (pervasive developmental disorder) must be documented by obtaining a copy of the school psychological and a copy of the IEP (Individualized Education Plan) Team report. Psychological evaluations from the school systems may be used for the identification of learning disability and may be considered along with data specified in the LD policy (*Appendix*). School psychological evaluations may also be used for the identification of intellectual disability if the IQ scores fall within the American Association on Mental Deficiency (AAMD) ranges used by VR for disability coding purposes; adaptive behavior deficits are present; and the individual is being served by the school system as intellectually disabled as evidenced on the IEP team report. In situations when the school psychologist and the IEP Team do not concur regarding placement for one of these three conditions, the counselor must use the disabling condition that corresponds to

the IEP team placement as evidenced on the IEP team report. Other diagnoses, such as emotional or behavioral disorders, require a valid DSM diagnosis (Diagnostic and Statistical Manual of Mental Disorders).

Evaluations from other sources such as educational institutions, government agencies, or institutions such as prisons, hospitals, or mental health clinics are considered valid sources of data as long as the evaluation is performed by or under the direction of one or more of the specialists listed above.

[34 CFR 361.42]

3-5-4: Shelf Life

The age validity or "shelf life" of an evaluation is dependent upon the impairment and counselor discretion. For the comprehensive assessment, up to date evaluations may be needed to show the current functioning or status of the individual's impairment; however, if the evaluation is for eligibility purposes in establishing the impairment, then the following guidelines for age validity apply:

A. For individuals currently in treatment there is no age requirement on existing data as long as the treatment has been provided by one or more of the specialists listed under 3-5-2, and has been uninterrupted. This would include individuals in correctional facilities who have been in treatment for the duration of their incarceration.

B. For individuals not currently in treatment, if a condition is defined by the DSM-IV-TR as a cognitive disorder, psychotic disorder, or mood disorder, individuals should be reevaluated if the information is more than five years from the date of application for services. Anxiety disorders, personality disorders, and mental and emotional disorders not elsewhere classified, require a reevaluation if the report is older than two years from the date of application for services.

C. For individuals not currently in treatment, if intellectual disability or another pervasive developmental disorder (i.e. autism) has been previously diagnosed and there has been no dramatic change in the client's environment or physical well being, then there is no age requirement on existing data.

D. For the diagnosis of Borderline Intellectual Functioning (BIF), a psychological evaluation may be considered as current for up to five years from the date of application for services.

E. For individuals not currently in treatment, reports providing the diagnosis of Attention Deficit/Hyperactivity Disorder have a shelf life of three years from the date of application for services.

F. If a learning disability (LD) has been previously diagnosed in a secondary education setting and the individual has been served under an IEP within the past two years, a school psychological evaluation with the IEP team report may be regarded as current for up to five years from the date of application for services. Other provisions specified in the LD policy (appendix) apply. For psychological reports providing the DSM diagnosis of learning disability, the five year shelf life also applies.

G. For individuals not currently in treatment, for purposes of the preliminary assessment, reports providing the diagnosis of substance abuse or dependence can be considered as current within one year of the date of application for services.

3-5-5: Special Conditions

The Division has established criteria to assist counselors in making decisions regarding the existence of an impairment that for some individuals may cause substantial impediments to employment. Service delivery staff should be very familiar with these conditions in order to assure that individuals with disabilities are evaluated consistently and fairly. The appendix contains policy entries addressing criteria the Division has established for the following impairments: Attention Deficit Disorder, Blind and Visually Impaired, Borderline Intellectual Functioning, Chronic Fatigue Syndrome, Chronic Pain, Cochlear Implants (Hearing Impairment), Dental Impairment, Hearing Disabilities, Human Immunodeficiency Virus (HIV Disease), Learning Disability, Intellectual Disability, Substance Abuse.

Section 3-6: Eligibility for Independent Living

3-6-1: Eligibility Criteria

IL services may be provided to an individual:

A. with a significant disability;
B. whose ability to function independently in the home or community, or whose ability to maintain employment is substantially limited;
C. who shall be an active participant in his/her own IL rehabilitation program, involved in making meaningful and informed choices about IL goals and objectives;
D. who shall be a full partner and share joint responsibility for planning and implementing his/her IL rehabilitation program; AND
E. for whom the delivery of IL services will:
    - improve or maintain the ability to maximize their independence in the home or community, OR
    - enable employment, OR
    - enable transition to VR.

3-6-2: Significant Disability

The classification of significant disability is based on the degree to which an individual's impairment results in barriers to independent living. The decision regarding significant disability will be documented in the record using the definitions presented in this subsection. Along with the definitions, counselor judgment is essential in determining the perceived degree of difficulty presented by the individualized nature of the disability relative to the extent of counselor time and involvement which will be required to reach the client's goals. The receipt of disability benefits (SSI/SSDI) implies the presence of a disabling condition that seriously limits one or more functional capacities, but does not automatically imply the significance of one's disability for Independent Living.

An individual with a significant disability is a person who:

A. Has a significant physical or mental impairment that seriously limits one or more functional capacities (Communication, Mobility, Self-Care, and/or Sustained Activity) in terms of an independent living outcome. "Seriously limits" means that the lack of functional capacity requires accommodations and/or interventions that cannot be easily achieved and that will be required permanently in order for the individual to achieve a successful independent living outcome,

AND

B. Requires multiple independent living services, whether provided by the Division or another provider, in order to complete an independent living rehabilitation program OR requires a permanent service(s) in the form of rehabilitation technology or personal assistance.

Definitions of Functional Capacity Areas (In order to demonstrate that an individual is "seriously limited," at least one of the following limitations must apply.)

COMMUNICATION: Communication is the ability to use, give, and/or receive information.

Functional Limitations include:

* Inability to speak intelligibly to people outside of the family
* Inability to communicate in the home or community without accommodations or assistive technology

MOBILITY: Mobility is the ability to move from place to place.

Functional Limitations include:

* Inability to drive without modifications and/or specialized training

* Inability to climb one flight of stairs or walk 100 yards without pause
or without adaptive equipment or personal assistance
* Demonstrated loss of driver's license due to physical impairment

SELF-CARE: Self-care is the ability to plan and/or perform daily activities.
Functional Limitations include:
***** Inability to perform activities of daily living (ADLs) without rehabilitation
technology or personal assistance
* Inability to plan and prepare meals
* Inability to use the phone or get help in case of an emergency

SUSTAINED ACTIVITY: Sustained activity is the ability to perform activities of daily life over a continuous period.
Functional Limitations include:
* Inability to participate in sustained productive activity in the home, community, or workplace without extended restorative rest.

3-6-3: Functional Improvement

The eligibility decision must include projected functional improvements in specified life areas; which include self-care, mobility, communication, residential, educational, and vocational.

3-6-4: Presumption of Eligibility

Eligibility for IL services is determined individually based on the criteria in Section 3-6-1. There is no presumption of eligibility for Independent Living Services.

3-6-5: Record of Service Documentation

Form ILRP-1004, Eligibility Decision must be completed on all individuals determined eligible for services. This form must be maintained in the case record and a copy given to the participant. The counselor must document:

A. The significant disability by recording the three-digit RSA disability code; AND
B. The areas and ways functioning will be improved with the provision of IL services.

The determination of significance of disability shall be documented on Form ILRP-1006.

Section 3-7: Priority of Services

The categories of service delivery for the IL program in priority order are to:

1. Provide for deinstitutionalization of persons with significant disabilities;
2. Prevent the institutionalization of persons with significant disabilities who are "at risk;"
3. Assist persons with significant disabilities towards community living; AND
4. Assist persons with significant disabilities towards employment transition.

3-7-1: Definitions

Deinstitutionalization: Client is currently living in an institution and needs IL services as part of their discharge plan.

Prevent Institutionalization: Client is currently living outside an institution. Documentation verifies that if IL services are not provided, the individual will be placed in an institution within the next 90 days.

Community Living: Client is currently living outside an institution and requires IL services to maintain and maximize independence. Client is not in immediate danger of being institutionalized.

Employment Transition: Client can benefit from joint IL and VR services to meet goals of independence and employment.

Section 3-8: Financial Need and Client Resources

3-8-1: Financial Statement

The scope of rehabilitation services available to an individual is determined by the services required by that individual in order to reach the IL goal. All services provided must be directly related to the achievement of the goal established in concert between the client and Rehabilitation Counselor.

Services Not Subject to Financial Need

For IL, financial need must be established prior to the planning and provision of any service subject to the financial needs test. The determination of financial needs is not applicable nor is completion of the *DVR-0116 Financial Statement* necessary for the following services (Unless otherwise specified, comparable benefits apply but would be addressed on the IPE, not on the *Financial Statement*.):

- Assessment (regardless of case status)*
- Guidance and counseling *(not subject to comparable benefits)*

- Consultation and technical assistance provided by Rehabilitation Engineers *(not subject to comparable benefits)*
- Recreational Therapy provided by IL staff
- Referral and collaborative efforts with other agencies
- Personal Assistance services sponsored by VR
- Driver Evaluation
- Foreign Language Interpreter/Translator
- Interpreter Services (Sign Language and Oral)
- Reader Services
- Note takers

Assessment includes any diagnostic/evaluative services provided:

- ***for the purpose of diagnosing or clarifying impairments (including secondary restoration issues) in applicant status (status 52),***
- ***as part of the IL needs assessment (status 60) for the purpose of determining rehabilitation needs,***
- ***in the service delivery statuses for IL for the purpose of further diagnosing, clarifying, or establishing treatment/rehabilitation needs for a primary/secondary impairment, or inter-current illness***
- ***in IL post-outcome (status 82)***

In cases in which the IPIL consists entirely of services from the above list (not subject to financial need), it would not be necessary to have a completed *DVR-0116, Financial Statement* in the case file. The counselor only addresses the appropriate financial need category (covered below) on the CATS financial statement screen.

Services Subject to Financial Need

Determination of financial need is required and the *DVR-0116* must be completed for the following services (Additionally, comparable benefits apply unless specified otherwise.):

- Assistive Devices/Equipment (including Durable Medical Equipment, IL Equipment, Tele-Communicative Devices, and Equipment Repairs)
- Day Care
- Driver Training
- Residence Modifications
- Purchase of Furniture and Appliances
- Maintenance
- Other Goods and Services
- Personal Assistance Services sponsored by IL
- Physical Restoration (hearing aids, orthotics, prosthetics, podiatry, visual services, chiropractic services, intercurrent illness, drugs and medical supplies, dental services, home health, speech therapy, physical therapy, occupational therapy)
- Recreational and Social Services not provided by IL staff
- Assistive Technology Services

- Vehicle and Worksite Modifications
- Services to Family Members
- Transportation (unless in conjunction with an assessment service)
- Purchase of Vehicle Insurance
- Sponsorship of Vehicle Repairs
- IL Skills Training

If services subject to the financial needs test are being provided, the counselor must continuously monitor financial need throughout the rehabilitation process with changes documented appropriately. Check stubs, State and Federal income tax forms and other information must be requested to document income or other financial resources. Counselors are required to request this information routinely when services requiring financial need are being planned or provided. Copies of the documents used for verification must be in the case record. If the individual does not have tax returns or check stubs, they will complete a verification form signed by their last employer, the individual who supports them, or the agency representative who processes the individual's public support. A letter from the agency, hospital or individual who can verify income status is an acceptable form of verification. Whenever the financial situation of the individual is unclear, the counselor will consult with the Unit Manager who must approve exceptions.

Determination Of Financial Need Category

Prior to completion of the IPIL, one of the following financial need categories must be selected (in CATS). Additionally, the following description of the categories provides instructions regarding:

- the sections to be completed on the *Financial Statement* for each category
- when it is necessary to print the completed Financial Statement for signatures and placement in the case file
- when Unit Manager approval is necessary

A. **Yes-Financial Needs Test Met**: Financial need is established to receive services subject to the financial needs test. Sections A - E are completed. The *DVR 0116, Financial Statement* must be printed for signatures and placed in the case record.

B. **No-Financial Needs Test is Not Met:** The client's excess resources exceed the cost of the rehabilitation program. Sections A-G are completed. The Division will not authorize or sponsor any services subject to the financial needs test. The *DVR-0116, Financial Statement* must be printed, with appropriate signatures and placed in the case record.

C. **Not Applicable:** Services planned are not subject to financial

need. It is not necessary to complete any sections on the form, print the form, or obtain any signatures.

D. **Extenuating Circumstances:** Client has excess resources but meets the financial needs test due to extenuating circumstances. All or part of the excess resource amount is waived. Sections A – G and the Remarks-Extenuating Circumstances-Justification Section are completed. The amount of the client's contribution must be recorded. The *DVR-0116* must be printed with appropriate signatures and placed in the case record. Unit Manager approval is required.

E. **Excess Income Applied:** Complete Sections A – G. It is not necessary to enter any comments in the *Remarks-Extenuating Circumstances-Justification Section*. Enter amount to be contributed and document details of the contribution on the form. The *DVR-0116* must be printed with appropriate signatures and placed in the case record. Unit Manager approval is required.

Resurvey Requirements

Financial need, once determined, must be continuously monitored throughout the rehabilitation process. A completed *DVR-0116, Financial Statement* must be resurveyed when there is a significant change in the individual's financial status, or when the time period established in Section F has expired. There are two methods for resurveying Financial Need if there is no significant change in income: (1) on the second page of *Form DVR-0116*, or (2) as part of the *IPIL Annual Review*. Whether using the second page of the *Financial Statement* or *IPIL Annual Review*, these two options may be used only for the first annual resurvey of the form and if there have been no significant changes in income. However, a new *DVR-0116* must be documented every two years or whenever an individual's financial resources change to the degree that financial need is affected. Once a new *DVR-0116* is completed, the aforementioned options for conducting the initial annual resurvey via the second page of the form, or the *IPIL Annual Review* are available under the conditions described above. During the annual resurvey, income must be verified if there are significant changes. When services subject financial need are added, the cost of the rehabilitation program must be recalculated with the additional cost of services included and excess income applied to the entire cost of the program.

Completion of Form DVR-0116

NAME and IL NUMBER: As noted in the record of service.

EFFECTIVE DATE

DETERMINATION OF FAMILY UNIT AND INCOME

A client is considered a family of one if:

A. Client is twenty-three years of age or older (*unmarried, not a tax dependent, and has no dependents)*; OR
B. Client is less than twenty-three AND one of the following:
    a. Ward of the court;
    b. Emancipated minor;
    c. Honorable discharged Veteran of the US Armed Forces; OR
    d. Can verify self-supported income and can produce receipts for basic living expenses (to include rent and utilities, medical payments, health insurance premiums, child care expenses, and legally mandated payments) for a minimum of three months.

If the client is married, the client's family shall include:

A. The client's spouse if residing in the same home;
B. The client's children, but not to include step-children; AND
C. Other individuals related to the client by blood, marriage, or adoption *if the other individuals have no income.*

If the client is less than twenty-three years old and is not married *or* if the client is 23 years of age or older and is being claimed as a dependent by the parents for tax purposes regardless of place of residence, the client's family shall include:

A. Client's parents, not including step-parents;
B. Siblings or half-siblings of the client, but not step-siblings, if the siblings are unmarried and less than 23 years of age;
C. Siblings or half-siblings of the client, but not step-siblings, if the siblings are 23 years of age or older and have no income; AND
D. Other individuals related to the client by blood, marriage, or adoption if the other individuals have no income.

A. MONTHLY RESOURCES

(A1) NET INCOME OF ALL APPLICABLE FAMILY MEMBERS NET WAGES:

Record the name and net monthly (biweekly x 2.17; weekly x 4.33) pay of *all members of the family unit.* Net income is typically considered for the thirty-day period prior to the date of the DVR-0116. In situations in which income1cannot be determined on that basis, the Counselor should calculate a fair representation of net monthly income. Income includes all cash income received from wages, salaries, or self-employment. Net income is computed by subtracting *mandatory* deductions from gross wages. Income does not include cash that minor children earn from babysitting, lawn mowing, or other miscellaneous tasks or gifts. Also, do not include Work Adjustment training earnings or work study as income. Check stubs must be requested to document income. If the individual does not have check stubs, the counselor will obtain *Form DVR-0301, Wage Verification,* signed by the current or last employer or *Form DVR-0302, Source of Support,* completed by the person who supports the individual or the agency representative who processes the individual's public support. In lieu of this form, a letter from the agency, hospital, or individual whom can verify income status is

an acceptable form of verification. Tax forms are acceptable if other documents are unavailable.

PENSIONS (SSDI, SSI, VA, etc.): Identify and record the total amount of the benefits received by all applicable family unit members. Included in this category are monetary benefits received from public assistance, retirement, and other pension benefits. Others may also apply.

COMPENSATION PAYMENTS (Unemployment, Worker's Compensations, etc.): Identify and record the total amount of the benefits received by all applicable family unit members.

COMMODITIES SOLD: Commodities are frequently produced and sold seasonally. The profit (income minus production costs) should be computed on a monthly basis.

OTHER: Identify and record all other available financial resources. Examples are income from stocks, bonds, savings accounts, investments, rentals, alimony, child support, GI Bill training benefits, sick pay, inheritances, life insurance payments, payments from trust funds, etc. Identify the source of the income and the amount.

SUBTOTAL (A1): Total lines 1 through 5.

(A2) ALLOWED DEDUCTIONS: Identify the recurring deductions and record the amount of monthly payments the family unit is making for any family member for the items or services listed below. If recurring deductions vary in amount from month to month, the average of the past three months will be calculated to determine the monthly allowed deductions. **Deductions must be verified by receipts, bill statements, and other information.** Documentation that the expense is actually being paid by a member of the family unit is needed as opposed to a verification of the expense with no evidence of payment. Include *only* those expenses not covered by a third party payer. Copies of the documents used to verify deductions must be in the record. **If it is not possible to verify deductions, the Unit Manager must approve exceptions to this requirement.**

MEDICAL EXPENSES: Medical expenses, dental expenses, medical supplies, prescription and non-prescription items. Special diets/foods that are related to the individual's disability may be considered. Also included are medical/health insurance premiums, if not already deducted from gross wages.

EQUIPMENT EXPENSES: Examples include disability-related clothing, devices, and equipment including necessary maintenance of such devices and equipment.

PERSONAL ASSISTANCE SERVICES (PAS): Examples include

domestic, chore, and other attendant-related services required to assist family unit members with activities of daily living and self-care needs. *Note:* If the client will require personal assistance services to achieve an independent living or employment outcome, an assessment of the individual's resources will occur. For Independent Living, if the individual meets the financial needs test, the individual's financial contribution toward the costs of the personal assistance services shall be one-half the excess net monthly family income, if applicable. For Vocational Rehabilitation, personal assistance is not subject to financial need. For both programs, comparable benefits must be utilized.

For IL Personal Assistance Services (PAS) Only: Clients for whom the IL Program is contributing or is considering contributing toward the cost of PAS, the PAS service must not be counted as an allowed deduction/disability-related expense on the part of the client. See below under** Excess Net Monthly Income **for further instructions on determining the client's contribution to PAS.

HOUSING/VEHICLE EXPENSES:

Housing: Payments for additional expenses necessitated by residing in an accessible residence; payments for specialized equipment in the residence. Examples are auditory alarms, specialized ventilation equipment, etc.

Vehicle: Due to the increased costs associated with purchasing and maintaining adapted vehicles, the Division has developed rates for modified automobiles and vans. If the individual owns or is purchasing a modified vehicle, a monthly deduction is granted, based on the information below.

Cost of Modification	Automobile	Van
Cost less than/equal to $1,000	$10.00	$149.00
Cost greater than $1,000 and less than $6,000	$60.00	$199.00
Cost greater than/equal to $6,000	$90.00	$229.00

CHILD CARE EXPENSES: Actual costs not to exceed $175.00 per month per child may be deducted for any child fourteen years old or younger, provided parents or other responsible adults are unavailable or unable to care for a child in the family unit.

POST-SECONDARY TRAINING EXPENSES: Actual costs not to exceed Division-allowed maximums for tuition, fees, books, and maintenance expenses may be deducted for applicable family unit members. *Note:*

Pro-rate the amount of training expenses to get a monthly amount to report as deduction.

LEGALLY MANDATED EXPENSES: Alimony, child support, or Social Security reimbursements may be deducted if required of any applicable family member. Other legally mandated payments cannot be deducted.

OTHER: Others may also apply.

SUBTOTAL (A2): This figure represents the total of allowed deductions as determined on the *Allowed Deductions-Worksheet.*

TOTAL MONTHLY RESOURCES (A1 – A2 = A): This figure represents the individual's total monthly resources.

B. ALLOWABLE NET MONTHLY INCOME: The Allowable Net Monthly Income amounts for family size one through eight are listed on the form. Add the designated amount (see form) per family member for each over eight. The appropriate amount should be recorded as *Total B* on the form.

C. EXCESS NET MONTHLY INCOME (A – B = C): This amount represents the monthly income available from the family unit, which can be applied toward the cost of the rehabilitation program. *Total C* represents the excess *cash* that can be applied toward the cost of the rehabilitation program.

For IL Personal Assistance Services (PAS) Only: Clients for whom IL Program is contributing or is considering contributing toward the cost of PAS, the PAS service must not be counted as an allowed deduction/ disability-related expense on the part of the client. The Counselor computes net income and family unit size to determine excess monthly income. The Counselor exempts ½ of the excess monthly income figure and applies the other half as the portion to be assumed by the client in the cost of rehabilitation services. The remaining cost of PAS services are sponsored by the IL Program.

D. AVAILABLE ASSETS:

CASH: Includes cash in checking or savings accounts, which exceeds an amount three times the *Allowable Net Monthly Income (B)* for the appropriate family size. Assets may include stocks, bonds, inheritances, lump sum insurance settlements, life insurance proceeds, gifts, or other resources the individual or the individual's family may have readily available to access.

REAL PROPERTY: Such property is an available asset to the extent it can be converted to cash or used as collateral, in a timely manner, to meet the cost of rehabilitation services. The local county tax office can

verify property information. Real property, excluding the individual's home site, will be recorded at the fair market value or purchase price; whichever is less, minus the amount owed for mortgages or liens. Any amount over $25,000.00 will be recorded as excess resources. If the residence is in a rural area, home site is defined as the house and land on which the residence is located up to a maximum of one-acre including all buildings on the acre. If the residence is in the city, home site is defined as the family unit's principle place of residence, including the house and lot plus all buildings on the lot.

TOTAL (D): Represents the amount of *Available Assets* that can be applied towards the cost of the rehabilitation program.

E. CONTRIBUTIONS: Record the total amount of community funds or other resources that the individual has available to contribute to the rehabilitation program. Contributions need to be reviewed during the resurvey with changes recorded.

TOTAL (E): Represents the amount of *Contributions* available for the family unit.

F. EXCESS RESOURCES: Complete this section when the amount in *(C), (D),* or *(E)* is greater than $0.00. The section addressing appropriate time period is the actual length of time for services planned on the rehab program, with three months as the minimum and twelve months is the maximum number of months. For example, restoration services may include the estimated recuperation period, etc., while training services would include the length of the training period.

TOTAL (F): Represents the sum of all *Excess Resources* that can be applied toward the cost of the rehabilitation program.

G. ESTIMATED COST OF REHABILITATION PROGRAM: If the amount in *(F)* is greater than $0.00, the counselor will estimate the cost of the entire rehabilitation program during the time period identified under *Excess Resources*. All services being planned on the rehab program should be recorded along with an estimated cost. *Total G* represents the *Estimated Cost* of the rehabilitation program.

If *Total (G)* is less than *Total (F)*, the individual does not meet the criteria for the financial needs test. If *Total (g)* is more than *Total (f)*, the individual does meet the criteria for the financial needs test and the Division may participate in the cost of certain services. The counselor must negotiate the actual amount of Division participation, as all of client's resources must be accounted for in the cost of the rehabilitation program.

REMARKS – EXTENUATING CIRCUMSTANCES – JUSTIFICATION: This section is provided to allow the counselor to identify other information related to

the individual's financial situation that will affect the individual's ability to participate in the cost of the rehabilitation program. If there are extenuating circumstances that prohibit the individual's application of part or all the excess resources toward the cost of rehabilitation, the Division may waive all or part of these resources. Such circumstances may include: the inability to sell property, the fact that the amount of funds would be so small that it would provide little substantial financial help toward the cost of rehabilitation program, or the fact that the conversion of the excess resources may result in undue delay in proceeding with the rehabilitation program.

If the individual's monthly resources change during the period of rehabilitation due to an inability to work, this should be recorded in this section. Written approval of the Unit Manager is required for the waiver. Verification of the particular circumstances must be provided by the individual and must be maintained in the record.

When there are excess resources of any type and financial need is reported as *Extenuating Circumstances,* this indicates that services subject to financial needs testing are planned on the IPIL; and there are extenuating circumstances that justify waiving all or part of the individual's contribution. Approval of the Unit Manager is required for the waiver. Documentation of the particular circumstances must be provided by the individual and maintained in the record.

The Counselor will identify the services for which the client's resources will be responsible and record the amount the individual is expected to contribute toward the cost of the rehabilitation program. The counselor will record the amount the individual is expected to contribute and towards which service(s).

The Counselor and individual must always sign the form once it is completed. The parent, guardian, or other representative must sign the form when appropriate. The Unit Manager is required to sign the form in all cases when there are excess resources, including resources that are due to comparable benefits such as educational grants.

H. SIGNATURES: The *DVR-0116, Financial Statement,* requires that the individual, or as appropriate, the individual's parent, guardian, other representative or advocate sign the completed form. The signature indicates that the financial information provided is correct and that the individual and/or the appropriate representative participated in the completion of this financial statement. The original *DVR-0116* and subsequent annual resurveys require the client or other appropriate signature as specified above.

[34 CFR 361.54; 10 NCAC 20C .0205 and .0206:); 34 CFR 364.59]

3-8-2: SSI and SSDI Recipients

Independent Living will apply a financial needs test for all participants requiring cost services regardless of the source of income. Vocational Rehabilitation will not apply a financial needs test or require the financial participation of any individual who receives Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI). Verification of these benefits must be documented in the case record. Services provided by Vocational Rehabilitation for these individuals must be directly related to the completion of the Individualized Plan for Employment or trial work experience. VR counselors must explore Social Security work incentives with these individuals as a part of the planning and development of the IPE. Comparable benefits must be utilized when available.

[34 CFR 361.54(b)(3)(ii)]

3-8-3: Comparable Benefits

The Division will provide rehabilitation services only when such services are not available from some other source as a comparable benefit or service. Comparable benefits are to be investigated and used for all rehabilitation services except those noted in Chapter 2 in this manual. This paragraph contains examples of comparable benefits. Others may be available and must be considered. Comparable benefits must be recorded on the IPIL under the COMPARABLE BENEFITS section. **By marking *"none"*, the rehabilitation counselor signifies that comparable benefits have been investigated but are not available for the stated service.** Comparable benefits must also be added to the IPIL whenever new services are added.

[34 CFR 361.53; State Plan Section6.11; Comparable Benefits: 10 NCAC 20C .0204]

Medicaid

The Division cannot supplant resources available through Medicaid. Therefore, Medicaid eligibility must be verified at the time of application and throughout the rehabilitation process. When appropriate, the counselor should refer the applicant or client to the local DSS for this verification. Medicaid may continue for SSI recipients who are disabled and earn over the SSI limits if they cannot afford similar medical care and depend on Medicaid in order to work. A threshold test and Medicaid use test will be applied to the individual situation to determine continuation of Medicaid eligibility (1619B).

The Division, regardless of the individual's financial need, cannot authorize Medicaid deductibles. If the client meets financial need but has a deductible and is unable to meet the deductible thus jeopardizing the ultimate rehabilitation goal, the counselor may elect to sponsor the

necessary medical services without Medicaid as a comparable benefit. The rationale for sponsoring necessary medical services without utilizing Medicaid is required in the case record. If the counselor determines that the client can meet the deductible, the Division will not contribute toward the cost of the medical services. Individuals who qualify for Medicaid because they are eligible for SSI are not subject to a spend-down.

Medicare

Medicare is an available comparable benefit for those individuals who meet the eligibility requirements for this program.

Health Insurance

Medical and related health insurance should always be used for any service applicable to the benefit. The counselor must assure that the vendor or the client pursues this benefit prior to payment for a rehabilitation service. Insurance paid directly to the individual must be used to offset Division payments, and the counselor must complete a *Subrogation Rights-Assignment of Reimbursement Form (DVR-0104)*

Worker's Compensation

If Worker's Compensation benefits are available, such benefits must be used prior to the expenditure of Division funds. If Worker's Compensation eligibility is pending or if there is an undue delay in service provision necessary for rehabilitation, the counselor may authorize services if *Subrogation Rights: Assignment of Reimbursement* form has been completed. (See 1-12 and 1-18)

Children's Special Health Services

Individuals 21 years old or younger who require medical and related support services, including equipment needed for medical reasons, should apply for services from this resource. More information can be obtained at:

http://www.dhhs.state.nc.us [See section for children and youth]

Requirements to use comparable benefits may be waived in the following situations:

A. Interrupts or delays the progress of the individual toward achieving the employment or independent living outcome identified in the IPIL
B. Jeopardizes an immediate job placement, or
C. Delays in the provision of a service placing the individual at extreme medical risk. (Extreme medical risk means a probability of substantially increasing functional impairment or death if medical services, including mental health services, are not provided expeditiously. This determination shall be based upon medical evidence provided by an appropriate qualified medical professional.

The counselor must continue to seek comparable benefits that might be retroactive and replace Division authorizations.)

These exceptions must have Unit Manager approval.

Social Security Work Incentives

Social Security work incentive options, Impairment Related Work Expense plans (IRWE) and Plans to Achieve Self-Support (PASS), must be explored and used when applicable with collaboration from the VR Counselor. Social Security's PASS Cadre Specialist approves and monitors PASSes.

[34 CFR 361.47; NC Administrative Code, Volume II Part B, Subchapter 20C, Sections .0204, .0205, and .0206: State Plan Section 6.3 and Section 6.6]

CHAPTER FOUR: REHABILITATION NEEDS ASSESSMENT

Section 4-1: Comprehensive Assessment

The purpose of the comprehensive assessment is to develop the IPIL and subsequent amendments. Once eligibility for IL services has been determined, the counselor, along with the client, should jointly identify and prioritize the independent living rehabilitation needs in relation to the development of the IPIL. The comprehensive assessment is conducted either simultaneously with the preliminary assessment or after an individual has been determined eligible for independent living services if additional data are necessary to develop the IPIL. The counselor and eligible individual must be able to identify the overall independent living objective, the goal(s), and the related services which will support the individual towards achieving a successful independent living outcome. The services planned must be anticipated to have a direct impact on the primary objective based on the stated rehabilitation needs. The independent living objective, goal(s), and services will be consistent with the unique strengths, resources, priorities, abilities, capabilities, interests, and informed choice of the individual.

The comprehensive assessment must be limited to a survey of information that is necessary to identify the rehabilitation needs of an eligible individual and to develop the IPIL such as:

- Existing information, including information that is provided by the individual, the family of the individual, and medical providers
- Functional Capacities Evaluation, Physical Therapy Evaluation, Occupational Therapy Evaluation, Personal Assistance Evaluation, Rehabilitation Engineering Evaluation, Assistive Technology Evaluation
- Medical, psychiatric, psychological, and environmental factors that affect the rehabilitation needs of the individual; AND
- Other rehabilitation services used for the purposes described below:

Any rehabilitation service may be provided during the comprehensive assessment to the extent that the service is necessary to achieve the purpose of the assessment, i.e., to identify the rehabilitation needs of the individual and to develop an IPIL that addresses those needs. Such services, when appropriate, should include assistive devices and services and rehabilitation technology. Financial need and comparable benefits must be considered relative to the service being provided. If the service being provided is a diagnostic service, the financial needs test is not required during the comprehensive assessment. Comparable benefits must be utilized for services when available.

[34 CFR 364.52]

Section 4-2: Record of Service Documentation

Documentation in the case record must include appraisal and analysis of the above categories of information. **All data used to complete the comprehensive assessment must be maintained in the record of service.** An analysis of the individual's rehabilitation needs is required and must be completed on *Form ILRP-1008, Written Rehabilitation Analysis Page (WRAP)*. The documentation of the Written Rehabilitation Analysis may be completed as a part of the combined preliminary and comprehensive assessment during applicant status (52) or as a part of the comprehensive assessment after eligibility has been determined in status 60. The WRAP should not be completed until all comprehensive assessment data has been received.

This analysis must include:

A. Identification of significant disability;
B. Substantial limitations;
C. Overall independent living objective (Priority Category);
D. Rehabilitation needs;
E. Selection of service(s) to meet rehabilitation need(s);
F. Projected functional Improvement (in specified life area) with provision of services; AND
G. Available comparable benefits and resources.

Counselors must document the provision of rehabilitation services, including the client's informed choice, necessary to complete this assessment. The IPIL represents the culmination of the comprehensive assessment by documenting the overall independent living objective, goal(s), and the nature and scope of services. The analysis on the WRAP must form the basis for the independent living objective, goal(s), and services.

CHAPTER FIVE: REHABILITATION PROGRAM

This chapter contains development and content requirements for the Individualized Plan for Independent Living (IPIL) for the IL program.

Section 5-1: IPIL General Information

5-1-1: Signatures

CROSS REFERENCE: **Subsection 1-13, Client Signatures**

The IPIL shall be agreed to and signed by the eligible client, or as appropriate, the client's parent, guardian, or power of attorney for the individual. The IPIL must also be approved and signed by the counselor.

Once all the required signatures have been secured, a copy shall be given the eligible client and the plan can be implemented.

5-1-2: Progress Review

This is a review conducted on a periodic basis to assess and document the client's progress towards completing the services required to achieve the long-range objective of the plan. This review may occur at any time during the service delivery process as deemed necessary by either the counselor or client. Such reviews should be documented as part of the IPIL. Clients are not required to sign the review but should be given an opportunity to participate in the review and are to receive a typed copy of the review. Services may be added to the IPIL as part of the progress review.

5-1-3: Annual Reviews

These reviews are required at least annually from the date of the original plan or subsequent annual review. Clients must be given the opportunity to participate in this review and will receive a typed copy. If the client chooses not to participate, and the annual review is conducted in the absence of the client, there must be documented evidence in the case record that the client was informed of and offered the opportunity to participate. Resurvey and documentation of a client's continued financial eligibility must occur during each annual review (review of *Form DVR-0116* as appropriate.)

5-1-4: Amendments

Amendments to the IPIL are required at any time when there are substantive changes in the independent living goals, services to be provided, or the service providers. These changes shall not take effect until the amendment is agreed to

and signed by the eligible client or the client's representative and the counselor. Copies of all amendments, once appropriately signed, will be given to the client.

Section 5-2: Development of the IPIL

CROSS REFERENCE: **Subsection 3-7-3**

5-2-1: Identification of the Overall IPIL Objective

Each eligible client accepted for services must identify the overall IL objective(s) so that a comprehensive program of services may be formulated to assist the client in relocating from an institution to community-based living or avoiding institutionalization for as long as possible; improving the ability to live more independently in the home, family, and/or community or to engage in or maintain employment.

5-2-2: IPIL Goals

The IPIL must identify goals in one or more of the general areas listed below. Each goal must have the date the goal is initiated and the date the goal is achieved.

Communication
Goals involving either improvement in a client's ability to understand communication by others (receptive skills), and/or improvement in a client's ability to share communication with others (expressive skills). **Note**: Hearing aids and augmentative communication systems would be included with this goal.

Community Services
Goals that provide for a change in living situations with increased autonomy for the client. This may involve a client's goals related to obtaining/modifying an apartment or house. **Note:** Services to aid in deinstitutionalization, housing placement and assistance, Section 8 or North Carolina Housing Finance Agency (NCHFA) housing, furniture packages, and utility/residence deposits would be included with this goal.

Educational
Goals of an academic or training nature that are expected to improve the client's basic knowledge or increase his/her ability to perform certain skills deemed to increase his/her independence consistent with IL philosophy. **Note:** Recreational Therapy services would be included with this goal.

Information Access/Technology
Goals related to a client obtaining and/or using a computer or other

assistive technology, devices, or equipment, also a client's goal of developing skills in using information technology, e.g., emerging computer screen-reading software.

Mobility/Transportation
Goals to improve a client's access to his/her life space, environment, and community. This may occur by improving the client's ability to move, travel, transport himself/herself, or use public transportation. **Note:** Transportation modifications, ingress/egress residence modifications, wheelchairs, orthotics and prosthetics would be included with this goal.

Personal Resource Management
Goals related to a client learning to establish and maintain a personal/family budget, managing a checkbook, and/or obtaining knowledge of available direct and in-direct resources related to income, housing, food, medical, and/or other benefits.

Self-Care
Goals to improve/maintain a client's autonomy with respect to activities of daily living such as personal grooming and cleaning, toileting, meal preparation, shopping, eating, etc. **Note:** Bathroom and/or kitchen modifications, personal assistance services, assistive aids for personal care, and emergency alert systems would be included with this goal.

Vocational
IL goals related to obtaining, maintaining, or advancing in employment. **Note:** This goal alone is not a legitimate goal for the IL program but would be utilized for all joint cases

5-2-3: Independent Living Services

The services planned to achieve the IL goals shall be recorded on the IPIL along with the anticipated initiation date of the service and the service provider chosen by the client. Services may be provided directly, purchased, or brokered by the program from another source or comparable benefit or service. The service provider chosen should be as specific as possible. If the service provider is not known at the time of IPIL completion, then it should be so noted. As soon as the service provider is ascertained, the IPIL should be updated to include this information. Any comparable benefit that is to be used to pay for the service should be listed along with the provider. Once a service is completed, the date achieved must be recorded on the plan.

5-2-4: Anticipated Services Following Successful Outcome

An assessment of the need for services that may be needed following successful outcome is required at the time of IPIL development. The counselor should be

cognizant of independent living needs, which may persist after the independent living goals are accomplished and a successful outcome is achieved. For joint cases with Vocational Rehabilitation, it should be noted that VR job placement services will continue after independent living goals are accomplished. If none are anticipated, this should be recorded.

5-2-5: Responsibilities

Information describing the responsibilities of both the Division and the client in meeting the terms and conditions of the IPIL should be recorded.

5-2-6: Integrated Setting and Informed Choice

All services must be provided in the most integrated setting appropriate consistent with the client's informed choice. If not, the rationale must be documented in this section of the plan.

CHAPTER SIX: RECORD OF SERVICE OUTCOMES

Section 6-1: Successful Outcome After IPIL-Case Status Code 76

6-1-1: Closure Standards

CROSS REFERENCE: **Subsection 4-1, Comprehensive Needs Assessment**

Clients whose records are closed in this status must meet the following criteria as documented in the case record:

A. The client was appropriately determined eligible for services;
B. Substantial services provided according to the IPIL must have had a direct impact on and contributed to the achievement of the primary IL objective;
C. The independent living outcome(s) is consistent with the client's strengths, resources, priorities, concerns, interests, and informed choice; AND
D. The client and the counselor consider the independent living outcome to be satisfactory and agree that the client has an improved level of independent living functioning and an enhanced involvement within their family, home, and community.

Clients cannot be closed with a successful outcome more than once in the same Federal fiscal year.

NOTE: IL program clients cannot have their records closed successfully (status code 76) from Transition to VR (status code 66) until the client has been determined eligible for vocational rehabilitation services.

6-1-2: Client Notification

The client is to participate in the decision to close the record to the extent possible.

6-1-3: Record of Service Documentation

The closure document (*Form ILRP-1010C, IL Successful Outcome*) should include the reason why it has been determined that the client has achieved the goal(s) and that the client has been informed of the availability and how to access post closure services. The client is to receive a copy.

Section 6-2: Outcome During Preliminary Assessment-Case Status Code 58

6-2-1: Closure Standards

Case status code 58 is a means of identifying all persons not accepted for service from applicant status. An annual review will be conducted on all individuals not accepted for service due to ineligibility. The IL program will conduct the initial review with subsequent reviews being initiated by the applicant. *Form ILRP-1005, IL Ineligibility Decision* is required when the applicant's record is closed due to ineligibility reasons—condition became too severe or does not meet the eligibility criteria.

6-2-2: Client Notification

The applicant must be given the opportunity to participate in the decision to close the case unless the applicant is unavailable or the disability is rapidly progressive or terminal. A copy of *Form ILRP-1005, IL Ineligibility Decision* is to be maintained in the applicant's file and a copy sent to the applicant.

6-2-3: Record of Service Documentation

The closure screen in CATS will be completed. A summary entry in the Case Notes is required justifying and outlining the closure decision. A copy of the *ILRP-1005, IL Ineligibility Decision,* is to be maintained in the applicant's file when case is closed due to ineligibility reasons. The reasons for ineligibility, applicant's input into the decision and review of the appeals process and annual review provisions should be documented.

Section 6-3: Outcome Prior to Implementation of the IPIL-Case Status Code 80

6-3-1: Closure Standards

This status is used when a client's record is closed after the client has been determined eligible, but prior to the development and initiation of the IPIL. If the closure is due to ineligibility, a review, at least annually, of the decision is required. The client is given the opportunity for full consultation in the reconsideration of the decision unless the individual refuses the review, is no longer present in the state, has unknown whereabouts, or has a medical condition that is rapidly progressive or terminal. The Division is responsible for initiating the first review while any subsequent reviews are undertaken at the request of the client. A *Form ILRP-1005, IL Ineligibility Decision* is required when the client's record is closed due to ineligibility reasons.

6-3-2: Client Notification

The client must be given the opportunity to participate in the decision to close the case regardless of the reason for closure. If issued, *ILRP-1005, IL Ineligibility Decision* is to be sent to the client.

6-3-3: Record of Service Documentation

An entry in the *Case Notes* is required stating why it has been determined that the client could not progress to the point of plan development or implementation and describing the views of the client regarding these determinations. If issued, a copy of the *ILRP -1005, Ineligibility Decision* is to be maintained in the client's file.

Section 6-4: Unsuccessful Outcome after Implementation of the IPIL- Case Status Code 78

6-4-1: Closure Standards

This case status code is used to close a client's record after the IPIL has been signed and there must be at least one service initiated which was planned for on the IPIL. If the closure is due to ineligibility, a review, at least annually, of the decision is required. The client is given the opportunity for full consultation in the reconsideration of the decision unless the client refuses the review, is no longer present in the state, has unknown whereabouts, or has a medical condition that is rapidly progressive or terminal. The Division is responsible for initiating the first review while any subsequent reviews are undertaken at the request of the client. *Form ILRP-1005, IL Ineligibility Decision* is required when the client is closed due to ineligibility reasons.

6-4-2: Client Notification

The client must be given the opportunity to participate in the decision to close the case regardless of the reason for closure. If issued, a copy of the *Form ILRP-1005, IL Ineligibility Decision* is to be sent to the client.

6-4-3: Record of Service Documentation

A closure document (*Form ILRP-1010D, IL Statement of Closure*) must be completed stating why it has been determined that the client could not progress to the point of rehabilitation and the views of the client must be included. Documentation must be part of the IPIL; however since closure for reasons other than ineligibility does not create the need for an IPIL amendment, the client's signature is not required although the client is to receive a copy.

If the record of service is being closed due to ineligibility, *Form-ILRP 1010,*

Amendment to the IPIL, to delete planned services which have not been provided is required and must be signed by the client. If issued, a copy of the *Form-ILRP-1005, Ineligibility Decision* is to be maintained in the client's file.

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CHAPTER SEVEN: POST-CLOSURE SERVICES

Section 7-1: Post-Closure Services-Case Status Code 82

Post closure services may be provided to those individuals who meet the following criteria:

A. The individual has successfully achieved the rehabilitation goal(s) and closed in case status code 76;
B. Continued services are needed in order to maintain the goal(s); AND
C. The problem is a continuation of the original rehabilitation need and the solution does not entail the need for a determination of eligibility and IPIL.

The primary purpose of this service is to assist the individual in maintaining the ability to function within the family or community or engage or continue in employment. Personal care services are the most common services rendered during this phase of the rehabilitation process. Services are subject to the same financial eligibility and comparable benefits requirements and described in CHAPTER 2. Should new problems arise that are not a continuation of the original or amended IPIL, the counselor will make a new determination of eligibility while assisting the client in identifying other resources outside the scope of the IL program. Sponsorship of acute medical conditions cannot be provided.

Individuals who may be generally considered candidates for post closure services include:

A. Those whom counselors identify prior to closure that will need services and for whom planning is outlined on the IPIL;
B. When unexpected situations arise after closure and very specific short-term services are required; OR
C. Those in the above group who may need long-term services but the problem is a continuation of the IPIL.

7-1-1: Procedure to Enter Post-Closure Services

Once the decision is made to provide services through post closure rather than opening a new case, the counselor will change the status to case status code 82.

7-1-2: Post-Closure Amendment to IPIL

The counselor and client must jointly amend the original IPIL describing the nature and scope of services planned and how they will be provided. There must be sufficient documentation in the record of service to explain why services are necessary to maintain the individual's goal(s).

Section 7-2: Termination of Post-Closure Services-Case Status 84

7-2-1: Termination Standards

Clients terminated from post closure services will have:

A. Been placed in case status code 82;
B. Had a program of services developed outlining the goal and need for post closure services; AND
C. Have completed the plan and maintained the goal or it has been determined that the client is in need of services outside the scope of post closure services and a new application will be evaluated for the development of a new record.

7-2-2: Client Notification

The client is to be involved in the decision to terminate post closure services and is to receive a copy of a closure statement summarizing the closure of the post-closure amendment. The summary should describe why services are being terminated.

7-2-3: Record of Service Documentation

When terminating a client from post closure services, it is necessary to document the reason for termination and the client's involvement in the decision. If a new application for services is taken, the new IL# and effective date of the application should be recorded in the *Case Notes.*

CHAPTER EIGHT: CENTERS FOR INDEPENDENT LIVING (CIL)

Section 8-1: Definition of a CIL

The purpose of a Center for Independent Living as authorized by Title VII of the Rehabilitation Act amendments is to promote a philosophy of independent living including a philosophy of consumer control, peer support, self-help, self-determination, equal access, and individual and system advocacy to maximize the leadership, empowerment, independence, and productivity of individuals with significant disabilities, and to promote and maximize the integration and full inclusion of individuals with significant disabilities into the mainstream of American society. A center will be designed and operated within local communities by individuals with disabilities, including an assurance that the center will have a board that is the principal governing body of the center and a majority of which must be composed of individuals with significant disabilities.

As per federal regulation, a center for independent living must provide the following independent living CORE services:

- Information and referral services
- IL skills training
- Peer counseling
- Individual and systems advocacy

While these core services are required in the federal regulations, other services may be provided as well based on the interests and development of an individual center.

[34 CFR 364.2, 364.4, and 366.50]

Section 8-2: Utilization of a CIL

Referral service relationships should be developed and maintained between the DVRS Independent Living Rehabilitation Program and the Centers for Independent Living to meet the comprehensive rehabilitation needs of the individual. The nature of the referral will vary depending upon the availability of a local CIL and the services provided by that CIL. In addition to the CORE services available through the CIL, other services may include nursing home transition, transportation and housing assistance, ADL equipment exchange, facilitation of ramp construction, and technology training. Where available, services shall be considered and utilized as comparable benefits when developing the IPIL. Financial need must be determined prior to purchasing services from the CIL.

APPENDIX

Appendix entries are alphabetized by topic heading.

Attention-Deficit/Hyperactivity Disorder (ADD/ADHD)

ADD/ADHD is a developmental disability with a history of childhood onset that typically results in a chronic and pervasive pattern of impairments in school, social and/or work domains and often in daily adaptive functioning as defined in the DSM-IV.

Diagnosis of ADD/ADHD must be made by psychologists, psychiatrists or neuropsychologists and reports have shelf life of three years.

IMPAIRMENT
Documentation of ADD/ADHD as an impairment must include the following components:

History
- Onset
- Pervasiveness
- Severity
- Previous/current treatment and response to treatment

Educational/Psychological Assessment
- Aptitudes
- Achievement
- Information Processing

Rule Out Presence of Co-morbid Conditions
While information from the school and medical sources should be included as a component of the assessment, this diagnosis must be based on DSM-IV criteria. Evaluation and diagnosis by a licensed psychologist or psychiatrist is required to establish the existence of mental, emotional or substance abuse impairments. (See Volume I, Section 3-5-2.)

SUBSTANTIAL IMPEDIMENT
Emphasis should be on the identification of the impediments to employment caused or created by the impairment.
Severity of symptoms is such that ongoing treatment is recommended and, as a result of the impairment, at least one of the following is present:

- Accommodations required to maintain suitable employment
- Inability to maintain suitable employment
- Poor school attendance, tardiness or inability to follow a schedule and meet deadlines
- School discipline issues due to poor problem solving
- Inability to anticipate consequence of behavior and actions
- Poor interpersonal skills due to lack of social judgment

Auxiliary Aids & Services

A public accommodation is required to provide auxiliary aids and services necessary to ensure equal access to the goods, services, facilities, privileges, or accommodations that it offers, unless an undue burden or fundamental alteration would result. A fundamental alteration is a modification that is so significant that it alters the essential nature of the goods, services, facilities, privileges, advantages, or accommodations offered.

This obligation extends only to individuals with disabilities who have physical or mental (impairments) disabilities, such as vision, hearing, or speech (impairments), that substantially limit the ability to communicate. Measures taken to accommodate individuals with other types of disabilities are covered by other title III requirements such as “reasonable modifications” and “alternatives to barrier removal”.

Auxiliary aids and services include a wide range of services and devices that promote effective communication. According to the Americans with Disabilities Act of 1990, Titles I and V, auxiliary aids and services includes:

- Qualified interpreters or other effective methods of making aurally delivered materials available to individuals with hearing (impairments) disabilities
- Note takers
- Computer-aided transcription services
- Telephone handset amplifiers
- Assistive listening devices and systems
- Telephones compatible with hearing aids
- Closed caption decoders
- Open and closed captioning
- Telecommunication devices for deaf persons (TDD);
- Videotext displays
- Exchange of written notes
- Qualified readers, taped texts, or other effective methods of making visually delivered materials available to individuals with visual (impairments) disabilities;
- Brailled materials
- Large print materials
- Computer terminals, speech synthesizers, and communication boards available to individuals with speech (impairments) disabilities
- Acquisition or modification of equipment or devices
- Other similar services and actions

Blind & Visually Impaired

NC DVRS will refer to the Division of Services for the Blind (DSB) the following individuals:

- All persons having 20/200 or worse vision in the better eye with best correction.
- All persons having between 20/100 and 20/200 in the better eye with best correction if the person has been unable to adjust to the loss of vision or if it is felt the individual needs the specialized services of DSB.
- All persons having night blindness, limited field of vision, or a rapidly progressive condition which in the opinion of a qualified eye specialist will reduce vision to 20/200 or less.

NC DVRS may accept individuals noted below as having an impairment:

- Persons having between 20/100 and 20/200 in the better eye with best correction if the individual has adjusted to the loss of vision and functions as a sighted person.
- Persons having between 20/60 and 20/100 in the better eye with best correction.
- Persons who have no vision in one eye with better than 20/100 with best correction in the other eye.
- Persons with a loss of vision with best correction of 25 % or more. Individuals with vision in one eye only are automatically classified as having a 25% loss of vision. Individuals without binocular vision or depth perception are classified as having useful vision in one eye only.

Borderline Intellectual Functioning

This impairment is diagnosed when there are deficits in adaptive behavior associated with an FSIQ measured in the range of 71-84. The adaptive behavior deficits must be identified by the psychologist, teacher, or the individual's family and must be stated or referenced in the psychological report. The psychologist may require such preliminary information about suspected or known behaviors prior to testing in order to establish the diagnosis. It is extremely unlikely that this impairment will ever be coded as SD.

Chronic Fatigue (CFS)

As a chronic condition, CFS represents an impairment which, on an individual basis, may result in substantial impediments to employment. An individual whose fatigue symptoms are not diagnosed as CFS may be determined to have an impairment of a different origin.

Interventions, other than those listed below, are considered experimental and should not be sponsored by the Division.

- An accurate explanation of the condition
- Supportive counseling
- Psychological assistance, including medication as prescribed
- Appropriate nutrition and rest
- Anti-inflammatory agents when joint and muscle pain persist
- An incremental program of increased activity with the aim of maximum increase in function

Chronic Pain

Important in an individual's approach to addressing chronic pain are both realizing that chronic pain may not be able to be totally eliminated and taking responsibility for the best management of any residual pain. In addition, utilizing surgical and other strongly overt approaches to symptom relief may often be avoided through first utilizing more conservative approaches.

Pain is a response of special sensory nerve endings to irritation, pressure, heat, cold, injury, stress, and disease. Emotional and attitudinal factors, previous experiences, other health conditions as well as social cultural and ethnic differences, however, can cause individuals to react differently to pain. Assisting the individuals we serve to assume responsibility not only for complying with specific treatment, but also encouraging the person's adapting an approach which takes a "holistic" or total mind and body approach will greatly enhance the likelihood of a return to a level of significant functioning.

CHRONIC PAIN INTERVENTIONS

Medical and Surgical

A physician experienced in the treatment of chronic pain and who seeks to understand the individualized and personal effect that pain of long duration may have had on the patient is most likely to utilize a comprehensive approach. While involving the psychologist and other team members, the potential influence of the physician in facilitating the consumer's assuming the responsibility for improvement is great. Surgery and other more overt interventions may be reasonable within the context of utilizing appropriate more conservative approaches initially.

Physical Exercise

A physician directed program of exercise to tolerance should be a part of nearly all treatment approaches. Improvement in metabolism and general physical conditioning helps to improve tolerance of residual pain in a variety of ways including reducing depression and subsequently improving sleep patterns. Walking, water exercises, and other personalized interventions have proven to often have a positive impact upon the individual's functional capacity even when residual pain persists.

Psychological

Through a psychological evaluation by a licensed practitioner experienced in assisting chronic pain patients, the individual and the treatment team can more fully learn about and address the role of depression, rewards and secondary gain that may come from having the condition, previous physically and emotionally traumatic experiences, and other factors that may be preventing optimal functioning. The psychologist may recommend specific stress reduction interventions that assist in demonstrating the

linkage between emotions and physical comfort. Problems with alcohol may also be identified and treatment addressed.

The psychologist's involvement with family members may be necessary to explore and surmount features in interpersonal relations that may contribute negatively to effective pain management and functional capacity.

Dietary

Good eating habits contribute to good general conditioning as well as to healing connective tissues damaged by inflammation. The individual may need to utilize a nutritionist for instruction in eating to maximize recovery.

Smoking Cessation

Assisting the individual to stop smoking through physician recommended smoking cessation services is another potential component in the comprehensive approach to pain management.

Alternative Medical Approaches

Alternative medical approaches have been gained increasing acceptance by the medical community during recent years. As with other interventions, the individual is best served when he or she views the treatment as a component in an overall approach to pain reduction and tolerance as opposed to a "cure all."

Recognizing the value of chiropractic treatment, the Agency has allowed the sponsorship of spinal manipulation for many years. When prescribed by a physician and performed by a licensed practitioner, acupuncture may be effective as a component in a comprehensive approach. Biofeedback, again when medically approved and performed by a qualified practitioner, can be effective in pain control and has been sponsored by the Agency for stress reduction. Massage therapy, under the prescription of a physician, when in compliance with any local ordinances that pertain (there is no state licensing), and when performed by a therapist certified by the National Certification Board for Therapeutic Massage and Bodywork is potentially of functional benefit. Since a series of the above listed treatments may need to be repeated should symptoms recur, individualized rehabilitation plans should assist in the client's assuming work activities that will both minimize the chances of pain exacerbation as well as provide the financial means for funding subsequent treatments that may be needed.

While some alternative medical therapies are consistent with physiological principles of western medicine, others are far outside the realm of accepted medical practice. The above mentioned interventions are among

those that have had significant acceptance by the medical community in the United States.

The National Institute of Health's Office of Alternative Medicine suggests that, in seeking a provider, one should select someone who is appropriately licensed and accredited who has significant experience in the specific application of the treatment for individual's particular pain treatment need. The provider should be able to offer references of other care providers who have recognized the benefit of the intervention with their patients. The client and practitioner alike need to realize that our sponsorship is for a finite number of treatment sessions and that subsequent treatment sponsorship will depend upon client cooperation, benefit having been realized with additional improvement expected, and progress toward the planned goal of the client's progressing toward being responsible for treatment costs.

The Division acknowledges the reduction of chronic pain that may be associated with many of these treatment modalities and supports short-term sponsorship as part of a total treatment approach under the direction and referral of a medical specialist. In view of the guarded prognosis when organic disease may be absent or insufficient to explain the pain condition, sponsorship of interventions requires diagnosis of the precipitating condition. Vendors must be certified and licensed as appropriate.

(See Volume VIII, Vendor Review and Certification.)

Cochlear Implants

Effective September 1, 1998, Medicaid approved the sponsorship of Cochlear Implants (CI) for children (ages 2-21) but not adults. At this time, Medicaid pays for the physician cost, the implant and hospitalization based on their fee schedule. Medicaid does pay for the speech processor.

The Division of Vocational Rehabilitation is not sponsoring the cochlear implant surgery. However, the counselor can sponsor external replacement parts for the CI such as the speech processor, microphone, coils, etc. for eligible clients with a CI through an approved vendor. The IPE must document this service as a core service under physical restoration that is provided within a supported guidance and counseling relationship. Please refer to Volume V for rates. Any questions regarding CI issues, please contact the Statewide Coordinator for Deafness and Communicative Disorders.

The external replacement parts may only be replaced or repaired by a licensed audiologist who has established a written plan of care that substantiates the need for the replacement or repair of external parts. These parts and rates are listed in Volume V. Upgrades to existing, functioning, replaceable speech processors to achieve aesthetic improvements are not medically necessary and will not be covered.

Although the Division does not sponsor the cochlear implant surgery; the following information is intended to provide Counselors with a general background of knowledge on the procedure. Listed below is a short description of the surgical procedure and process that a client may follow for maximum benefit from the CI. The use of cochlear implantation is still relatively new. The small, snail-shaped electrical devices are surgically implanted in the cochlea, the inner-ear organ that contains nerve endings needed for hearing (under the skin behind the ear). Sound waves enter the microphones, which are then sent via a thin cable to a speech processor that may be worn on a belt or a behind-the-ear model.

The speech processor is a powerful miniature computer that translates incoming sounds into distinct electrical codes. The speech signal is sent back up the same cable, to the headpiece and transmitted across the skin via radio waves to the implanted device. This signal then travels down to the electrode array, which has been positioned within the inner ear and stimulates the auditory nerve. While the implants do not restore normal hearing, they bypass defective parts of the ear and send auditory signals to the brain.

Possible Pre-operative Required Testing for Consumers

A. Hearing Evaluation
B. Speech Discrimination Testing

C. Tympanometry
D. Acoustic Reflex Testing
E. Auditory Brainstem Response Testing (ABR)
F. Promontory Stimulation Test
G. Consultative Pre Cochlear Implant
H. Other tests and/or services as required

Implant Procedure

A. Hospitalization
B. Anesthesiology
C. Radiology
D. Cochlear Implant Devices/System

Post-Operative Activities

A. Audiological (Aural) Rehabilitation–Post Surgery
B. Speech Processor Programming & Therapy
C. Final Testing
D. Other tests and/or services as required

Dental Impairments

Dental impairments create certain difficulties for service delivery staff in determining whether such conditions are severe enough to cause vocationally-related difficulties. Consequently, the Division has developed the following contingencies related to this impairment:

- COSMETIC APPEARANCE - An impairment may be present if the individual encounters rejection in social and employment-related situations due to the severity of the cosmetic appearance.
- CHRONIC DENTAL CARIES or other Severe Dental Problems - An impairment may exist if the condition is so severe that pain and discomfort interferes with normal functioning. Likewise, the impairment may prevent the individual from maintaining control or treatment of another medical condition.

The dentist or other physician must document that either or both of the above conditions are present.

Disabling Condition

DISABILITY CODING

PRIMARY IMPAIRMENT -- The major disabling condition is the major impairment, defector disease most significantly responsible for the client's independent living or vocational limitation(s).

SECONDARY IMPAIRMENT -- A secondary disabling condition is a second impairment, residual defect or other disabling condition that contributes to, but is not the major source of, the independent living or vocational limitation(s). If the participant has a secondary disabling condition, enter the appropriate code. The secondary disability code cannot equal the major disability, except code 888 may be used for both. If the individual does not have a secondary disabling condition, enter code "999."

General Instructions: The disability or disabilities described and subsequently coded should be accurate and in the best professional judgment of the counselor. Codes 100 through 449 pertain to conditions which affect particular parts of the body and have specific causes. The first two digits of these codes pertain to the disabling condition itself, and the last digit to the cause of the condition. Thus, if a participant is missing at least one upper and one lower extremity (40-) due to an accident, injury, or poisoning (--9), the disability code would be 409.

Codes 500 through 699 pertain to disabling conditions where specific body sites generally are not involved and etiology is not usually appropriate. These codes are not to be used if the disabling condition is a visual, hearing, or orthopedic impairment or an amputation (codes 100-499).

Example: A diabetic condition has led to the amputation of both legs. The proper code would be 434 rather than code 614 (diabetes Mellitus). The code for diabetes would be used only when the disability is not significantly associated with eyes, ears, limbs, digits, or trunk, and the diabetes, itself, is the condition that contributes primarily toward the work limitation.

Cases may occasionally involve two codes in the 500 through 699 series such as benign neoplasm (609) leading to a cardiac condition (643). In this case, use code 643.

Code 888, disabling condition unknown/undetermined, may be entered if case is being closed in status 58 (IL) or 08 (VR) [from applicant status 52 (IL) or 02 (VR) only] because personal contact with the participant could not be ascertained prior to closure.

I. CLASSIFICATION OF DISABLING CONDITIONS

VISUAL IMPAIRMENTS	
Blindness, both eyes, no light perception, due to:	
100	cataract
101	glaucoma
102	diseases unspecified in code listing
106	congenital condition
107	accident, injury or poisoning
109	ill-defined, unspecified or unknown cause
Blindness, both eyes (with correction not more than 20/200 in better eye or limitation in field within 20 degrees, but not codes 100-109), due to:	
110	cataract
111	glaucoma
112	diseases unspecified in code listing
116	congenital condition
117	accident, injury or poisoning
119	ill-defined, unspecified or unknown cause
Blindness, one eye, other eye defective (better eye with correction less than 20/60, but better than 20/200, or corresponding loss in visual field, due to:	
120	cataract
121	glaucoma
122	diseases unspecified in code listing
126	congenital condition
127	accident, injury or poisoning
129	ill-defined, unspecified or unknown cause
Blindness, one eye, other eye good, due to:	
130	cataract
131	glaucoma
132	diseases unspecified in code listing
136	congenital condition
137	accident, injury or poisoning
139	ill-defined, unspecified or unknown cause
Other visual impairments, due to:	
140	cataract
141	glaucoma
142	diseases unspecified in code listing
HEARING IMPAIRMENTS	
Deafness, pre-lingual, due to:	
231	congenital condition
233	degenerative or infectious disease
234	accident, injury or poisoning
239	ill-defined, unspecified or unknown cause
Deafness, pre-vocational, due to:	

241	(Do not use)
243	degenerative or infectious disease
244	accident, injury or poisoning
249	ill-defined, unspecified or unknown cause
Deafness, post-vocational, due to:	
251	(Do not use)
253	degenerative or infectious disease
254	accident, injury or poisoning
259	ill-defined, unspecified or unknown cause
Hard of hearing, pre-lingual, due to:	
261	congenital condition
263	degenerative or infectious disease
264	accident, injury or poisoning
269	ill-defined, unspecified or unknown cause
Hard of hearing, pre-vocational, due to:	
271	(Do not use)
273	degenerative or infectious disease
274	accident, injury or poisoning
279	ill-defined, unspecified or unknown cause
Hard of hearing, post-vocational, due to:	
281	(Do not use)
283	degenerative or infectious disease
284	accident, injury or poisoning
289	ill-defined, unspecified or unknown cause
DEAF-BLIND (See definition after code listing)	
Combined visual and hearing loss, as indicated:	
290	both congenital
292	both adventitious
294	visual loss congenital-hearing loss adventitious
296	hearing loss congenital-visual loss adventitious
298	ill-defined, unspecified or unknown cause
ORTHOPEDIC IMPAIRMENTS, EXCEPT AMPUTATIONS	
Impairment involving three or more limbs or entire body, due to:	
300	cerebral palsy
301	congenital condition or ill-defined birth injury
303	diseases unspecified in code listing
310	arthritis and rheumatism
312	intracranial hemorrhage, embolism, and thrombosis (stroke)
314	poliomyelitis
315	muscular dystrophy
316	multiple sclerosis
317	Parkinson’s disease
318	accidents and injuries involving the spinal cord
319	all other accidents, injuries and poisonings
Impairment involving one upper and one lower limb (including side), due to:	

320	cerebral palsy
321	congenital condition or ill-defined birth injury
323	diseases unspecified in code listing
330	arthritis and rheumatism
332	intracranial hemorrhage, embolism, and thrombosis (stroke)
334	poliomyelitis
335	muscular dystrophy
336	multiple sclerosis
337	Parkinson's disease
338	accidents and injuries involving the spinal cord
339	all other accidents, injuries and poisonings
Impairment involving one or both upper limbs (including hands, fingers, and thumbs), due to:	
340	cerebral palsy
323	diseases unspecified in code listing
330	arthritis and rheumatism
332	intracranial hemorrhage, embolism, and thrombosis (stroke)
334	poliomyelitis
335	muscular dystrophy
336	multiple sclerosis
337	Parkinson's disease
338	accidents and injuries involving the spinal cord
339	all other accidents, injuries and poisonings
Impairment involving one or both upper limbs (including hands, fingers, and thumbs), due to:	
340	cerebral palsy
341	congenital condition or ill-defined birth injury
343	diseases unspecified in code listing
350	arthritis and rheumatism
352	intracranial hemorrhage, embolism, and thrombosis (stroke)
354	poliomyelitis
355	muscular dystrophy
356	multiple sclerosis
357	Parkinson's disease
358	accidents and injuries involving the spinal cord
359	all other accidents, injuries and poisonings
Impairment involving one or both lower limbs (including feet and toes), due to:	
360	cerebral palsy
361	congenital condition or ill-defined birth injury
363	diseases unspecified in code listing
370	arthritis and rheumatism
372	intracranial hemorrhage, embolism, and thrombosis (stroke)

374	poliomyelitis
375	muscular dystrophy
376	multiple sclerosis
377	Parkinson's disease
378	accidents and injuries involving the spinal cord
379	all other accidents, injuries and poisonings
Other and ill-defined impairments (including trunk, back, and spine), due to:	
380	cerebral palsy
381	congenital condition or ill-defined birth injury
382	spina bifida (state codes est. 1993)
383	diseases unspecified in code listing
390	arthritis and rheumatism
392	intracranial hemorrhage, embolism, and thrombosis (stroke)
394	poliomyelitis
395	muscular dystrophy
396	multiple sclerosis
397	Parkinson's disease
398	accidents and injuries involving the spinal cord
399	all other accidents, injuries and poisonings
ABSENCE OR AMPUTATION OF MAJOR AND MINOR MEMBERS	
Loss of at least one upper and one lower major extremity (including hands, thumbs, and feet), due to:	
400	malignant neoplasm
402	congenital condition
404	diseases unspecified in code listing
409	accident, injury or poisoning
Loss of both major upper extremities (including hands or thumbs), due to:	
410	malignant neoplasm
412	congenital condition
414	diseases unspecified in code listing
419	accident, injury or poisoning
Loss of one major upper extremity (including hand or thumb), due to:	
420	malignant neoplasm
422	congenital condition
424	diseases unspecified in code listing
429	accident, injury or poisoning

Loss of one or both major lower extremities (including feet), due to:	
430	malignant neoplasm
432	congenital condition
434	diseases unspecified in code listing
439	accident, injury or poisoning
Loss of other unspecified parts (including fingers and toes, but excluding thumbs), due to:	
440	malignant neoplasm
442	congenital condition
444	diseases unspecified in code listing
449	accident, injury or poisoning
OTHER DISABLING CONDITIONS (for which etiology is not known or not appropriate) **NOTE:** ONLY CODES 500 and 522 WILL BE CLASSIFIED AS "MENTAL ILLNESS"	
Mental and emotional conditions:	
500	psychosis disorders
510	neurosis disorders
520	alcohol abuse or dependence
521	other drug abuse or dependence
522	other mental and emotional disorders
526	autism
529	borderline intellectual functioning
530	intellectual disability, mild (AAMD Nomenclature IQ range 55-74)
532	intellectual disability, moderate (AAMD Nomenclature IQ range 40-54)
534	intellectual disability, severe AAMD Nomenclature IQ range 25-39)
Conditions resulting from neoplasms, not elsewhere classified:	
600	colostomies resulting from malignant neoplasms
601	laryngectomies resulting from malignant neoplasms
602	leukemia and aleukemia
605	other malignant neoplasms
609	benign and unspecified neoplasms
Allergic, endocrine system, metabolic and nutritional diseases:	
610	asthma and hay fever
611	other allergies
614	diabetes mellitus

615	other endocrine system disorders (except 616, cystic fibrosis)
616	cystic fibrosis
619	avitaminoses and other metabolic diseases
Diseases of the blood and blood-forming organs:	
620	hemophilia
621	sickle cell anemia
629	other anemia and diseases of the blood and blood-forming organs (except code 602, leukemia and aleukemia)
Other disorders of the nervous system:	
630	epilepsy - if not seizure-free for two years
632	learning disabilities
639	other disorders of the nervous system, not elsewhere classified
Cardiac and circulatory system conditions:	
640	congenital heart disease
641	rheumatic fever and chronic rheumatic heart disease
642	arteriosclerotic and degenerative heart disease
643	other diseases or conditions of the heart
644	hypertensive heart disease
645	other hypertensive disease
646	varicose veins and hemorrhoids
649	other conditions of circulatory system
Respiratory system conditions:	
650	tuberculosis
651	emphysema
652	pneumoconiosis and asbestosis
653	bronchiectasis
654	chronic bronchitis and sinusitis
659	other conditions of respiratory system
Digestive system conditions:	
660	conditions of teeth and supporting structures
661	ulcer of stomach and duodenum
662	chronic enteritis and ulcerative colitis
663	hernia
664	colostomies (except Code 600, those resulting from malignant neoplasms)
669	other conditions of digestive system
Genitourinary system conditions:	
670	genitourinary system conditions (except code 671, end-stage

	renal failure)
671	end-stage renal failure
Speech impairments:	
680	cleft palate (with or without cleft lip), with speech imperfections
682	stammering and stuttering
684	laryngectomies (except Code 601, those resulting from malignant neoplasms)
685	aphasia, resulting from intracranial hemorrhage, embolism, or thrombosis (stroke)
689	other speech impairments
Other disabling diseases and conditions, not elsewhere classified:	
690	diseases and conditions of the skin and cellular tissue
699	all other disabling diseases and conditions
Traumatic brain injury leading to:	
700	blindness, both eyes no light
702	blindness, both eyes, some light perception
704	blindness, one eye, other eye defective
706	blindness, one eye, other eye good
708	other visual impairments
710	deafness, pre-lingual
712	deafness, pre-vocational
714	deafness, post-vocational
716	hard of hearing, pre-lingual
718	hard of hearing, pre-vocational
720	hard of hearing, post vocational
722	orthopedic impairment involving three or more limbs or entire body
724	orthopedic impairment involving one upper and one lower limb (including side)
726	orthopedic impairment involving one or both upper limbs (including hands,
728	orthopedic impairment involving one or both lower limbs (including feet and toes)
730	other and ill-defined orthopedic impairments (including trunk, back and spine)
732	psychotic disorders
734	neurotic disorders
736	other mental and emotional disorders
738	epilepsy
740	learning disabilities

742	speech impairments
744	all other disabling conditions not elsewhere classified or with multiple effects
GENERAL CODES	
888	disabling condition unknown/undetermined
999	no secondary disabling condition

II. Special Instructions for Recording Hearing Impairments, Mental and Emotional Conditions and Intellectual Disability:

Definitions for Terms Used in Coding Hearing Impairments:
DEAFNESS: A hearing impairment of such severity that the individual must depend primarily upon visual communication such as writing, lip reading, manual communication, and gestures.

HARD OF HEARING : A hearing impairment resulting in a functional loss, but not to the extent that the individual must depend primarily upon visual communication.

PRE-LINGUAL HEARING IMPAIRMENT : An impairment that is known or is assumed to have occurred prior to the third birthday.

PRE-VOCATIONAL HEARING IMPAIRMENT: An impairment that is known or is assumed to have occurred on or after the third birthday, but prior to the 19th birthday.

POST-VOCATIONAL HEARING IMPAIRMENT: An impairment that is known or is assumed to have occurred on or after the 19th birthday.

CONGENITAL CONDITION: A hearing loss that is known or assumed to have been present at birth. Examples would include, but not be limited to, maternal rubella and hemolytic disease of the newborn.

DEGENERATIVE OF INFECTIOUS DISEASE : A cause of hearing loss that would include, but not be limited to, meningitis, scarlet fever and diphtheria. (NOTE: A condition present at birth which does not result in a hearing loss until later in life is, for reporting purposes, caused by “degenerative or infectious disease”.)

ACCIDENT, INJURY OR POISONING: A traumatic cause of hearing loss, including noise-induced loss. This cause would encompass, but not be limited to, ototoxic agents.

Definition of Deaf-Blindness

The term “individual who is deaf-blind” means any individual:

A. who has a central visual acuity of 20/200 or less in the better eye with corrective lenses, or a field defect such that the peripheral diameter of visual field subtends an angular distance no greater than 20 degrees, or a progressive visual loss having a prognosis leading to one or both of these conditions;
B. who has a chronic hearing impairment so severe that most speech cannot be understood with optimum amplification, or a progressive hearing loss having a prognosis leading to this condition; AND
C. for whom the combination of impairments described in clauses A and B causes extreme difficulty in attaining independence in daily life activities, achieving psychosocial adjustment or obtaining a vocation;

AND

who, despite the inability to be measured accurately for hearing and vision loss due to cognitive or behavioral constraints, or both, can be determined through functional and performance assessment to have severe hearing and visual disabilities that cause extreme difficulty in attaining independence in daily life activities, achieving psychosocial adjustment or obtaining vocational objectives.

The Classification and Coding of Intellectual Disability

The essential features of intellectual disability are: (1) significant sub-average intelligence functioning, (2) resulting in or associated with deficits or impairments in adaptive behavior, (3) with onset before the age of 18.

Significant subaverage intellectual functioning is defined as an IQ of 74 or below on an individually administered IQ test by a psychologist. Regardless of IQ scores, documented evidence of deficits in adaptive behavior are the critical elements in determining eligibility on the basis of intellectual disability. A measured IQ in and of itself is insufficient diagnostic evidence to establish eligibility for a program of IL rehabilitation services.

Adaptive behavior refers to the effectiveness with which an individual meets the standard of personal independence and social responsibility expected of his or her age and cultural group. There are scales designed to quantify adaptive behavior, but none is considered reliable and valid to be used alone to evaluate this aspect of functioning. Therefore, clinical judgment is necessary for the assessment of general adaptation, the individual’s age being taken into consideration.

The IQ level of 74 was chosen as the upper limit for intellectual disability because most people with IQs below 74 are so limited in their adaptive functioning that they require special services. The arbitrary IQ ceiling values are based on data indicating a positive association between intelligence (as measured by IQ score)

and adaptive behavior. This association declines at the upper levels of Mild Retardation. Some individuals with an IQ near but below 74 may not have the impairment in adaptive behavior required for a diagnosis of Intellectual Disability.

> MILD: Code 530. According to present AAMD nomenclature, descriptive of retarded persons whose IQ falls in the 55 through 74 range. With proper training, these persons should achieve some academic skills, personal and social adequacy, and vocational adjustment. These individuals may need assistance in social or economic stress situations throughout their lives.
> MODERATE: Code 532. According to present AAMD nomenclature, descriptive of individuals whose IQ falls in the 40 through 54 range. These persons may always need supervision but with proper training should achieve adequate skills in self-help and communication and are often able to work with support. These individuals generally will not master academic skills (Trainable).
> SEVERE: Code 534. Present AAMD nomenclature, descriptive of individuals whose IQ fall in the 25 through 39 range. Goals are for development of self-help skills and with intensive and prolonged training these people may be able to function in a highly controlled and supervised workshop facility or in supported employment. These individuals will always need fairly complete supervision.

(If the psychologist reports the IQ range, rather than the actual score, the counselor should use the mid-point of the range, i.e., Mild - 65, Moderate - 47, and Severe - 32.)

It is the behavioral component of intellectual disability rather than the measured intelligence quotient which is more meaningful in determining the individual's need for independent living services as well as his/her ultimate potential on the completion of such services. At the same time, it must be realized that the IQ can be of great importance to the counselor, especially in the applicant's or participant's readiness for specific training, for example.

While there are no objective scales which will determine with reasonable objectivity the functioning level of adaptive behavior to which a person with intellectual disability should be assigned, such measures as the Vineland Social Maturity Scale and others may be helpful in this regard. It will, then, be necessary for the counselor, in collaboration with the psychologist, to make a judgment on the proper observations of the applicant/participant, a careful review of the case history together with the results of a comprehensive medical-psychological-educational evaluation, reports from schools and other agencies which may have been involved in the case, and such other sources of information as may be available.

III. Codes for Mental and Emotional Conditions Using Terms from the

American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)

500 – Psychotic Disorders DSM-IV Categories

A. Schizophrenic disorders
B. Paranoid disorders
C. Major affective disorders (bipolar disorder and major depression)
D. Atypical affective disorders
E. Organic disorders, other than substance-induced
F. Psychotic disorders, not elsewhere classified

510 – Neurotic Disorders DSM-IV Categories

A. Anxiety disorders
B. Somatoform disorders
C. Dissociative disorders
D. Dysthymic disorder - other specific affective disorders (depressive neurosis)
E. Disorders usually first evident in infancy, childhood or adolescence, not elsewhere classified
    - anxiety disorders of childhood or adolescence
    - eating disorders
    - stereotyped movement disorders
    - other disorders of infancy, childhood or adolescence (except conduct disorders and attention deficit disorders, both coded 522, and autism, coded 526)

520 - Alcohol Abuse or Dependence DSM-IV Categories

A. Substance use disorders - abuse of and dependence on alcohol
B. Organic mental disorders, as induced by alcohol

521 - Other Drug Abuse or Dependence DSM-IV Categories

A. Substance use disorders - abuse of and dependence on drugs other than alcohol
B. Organic mental disorders, as induced by drugs other than alcohol

522 - Mental and Emotional Disorders, Not Elsewhere Classified DSM-IV Categories

A. Personality disorders (DSM-IV Axis II category)
B. Conduct disorders of childhood or adolescence
C. Attention deficit disorders of childhood or adolescence
D. Cyclothymic disorders - other specific affective disorders
E. Psychosexual disorders
F. Factitious disorders
G. Disorders of impulse control, not elsewhere classified

529 - Borderline Intellectual Functioning

A. This diagnosis is given when there are deficits in adaptive behavior associated with Borderline Intellectual Functioning which is generally in the IQ range of 71-84.

B. Applicants who are diagnosed as having Borderline Intellectual Functioning based on psychological test results and deficits in adaptive behavior can be considered as having a disabling condition. The extent to which this condition is a handicap to employment depends largely on the deficits in adaptive behavior identified by the psychologist, the applicant, the teacher or the family of the applicant. Deficits in adaptive behavior must be identified or referenced in the psychological report and the psychologist may, in fact, need preliminary information about this behavior prior to testing, in order to establish the diagnosis.

C. It is rare that Borderline Intellectual Functioning would be classified as Significantly Disabled according to Federal criteria.

Driver Evaluation & Training Services: Procedures for Obtaining Driving Evaluation When Adaptive Driving Equipment Is Involved

{This appendix insert replaces Policy Directive 04-2004 dated 09/14/2004}

Since September 14, 2004, counselors were directed to utilize one or two specific rehabilitation engineers per region who were to serve as point persons assisting counselors with matching the various driving evaluation providers and their capabilities with the specific needs of the consumer. Additionally, these "designated engineers" also reviewed the driving evaluations for purposes of verifying their compliance with the Division's requirements prior to payment for services rendered. Over the course of that period, we have been able to improve the quality of the driving evaluations purchased and were able to strengthen all staff rehabilitation engineer's ability to provide these services.

Effective April 20, 2007, we are requesting for all counselors who wish to obtain driving evaluations or training for clients involving adaptive equipment to contact the rehabilitation engineer from which they normally obtain all rehabilitation engineering services. They will guide the counselor through the resources, forms and procedures for obtaining these services.

One of the benefits of this new approach is that the rehabilitation engineer with whom the counselor normally partners can remain an integral part of the process from the very moment that a counselor determines that a driving evaluation should be pursued for a given client. It also should be less confusing for counselors to work with the rehabilitation engineer that they normally partner with on all rehabilitation engineering-related matters.
As a reminder, the following types of driver evaluation/training services are NOT included in this process:

- Clinical evaluations for purposes unrelated to adaptive equipment purchases, e.g., cognitive-perceptual types of evaluations often purchased through outpatient rehab centers.

- Driver's training where no adaptive equipment is involved.

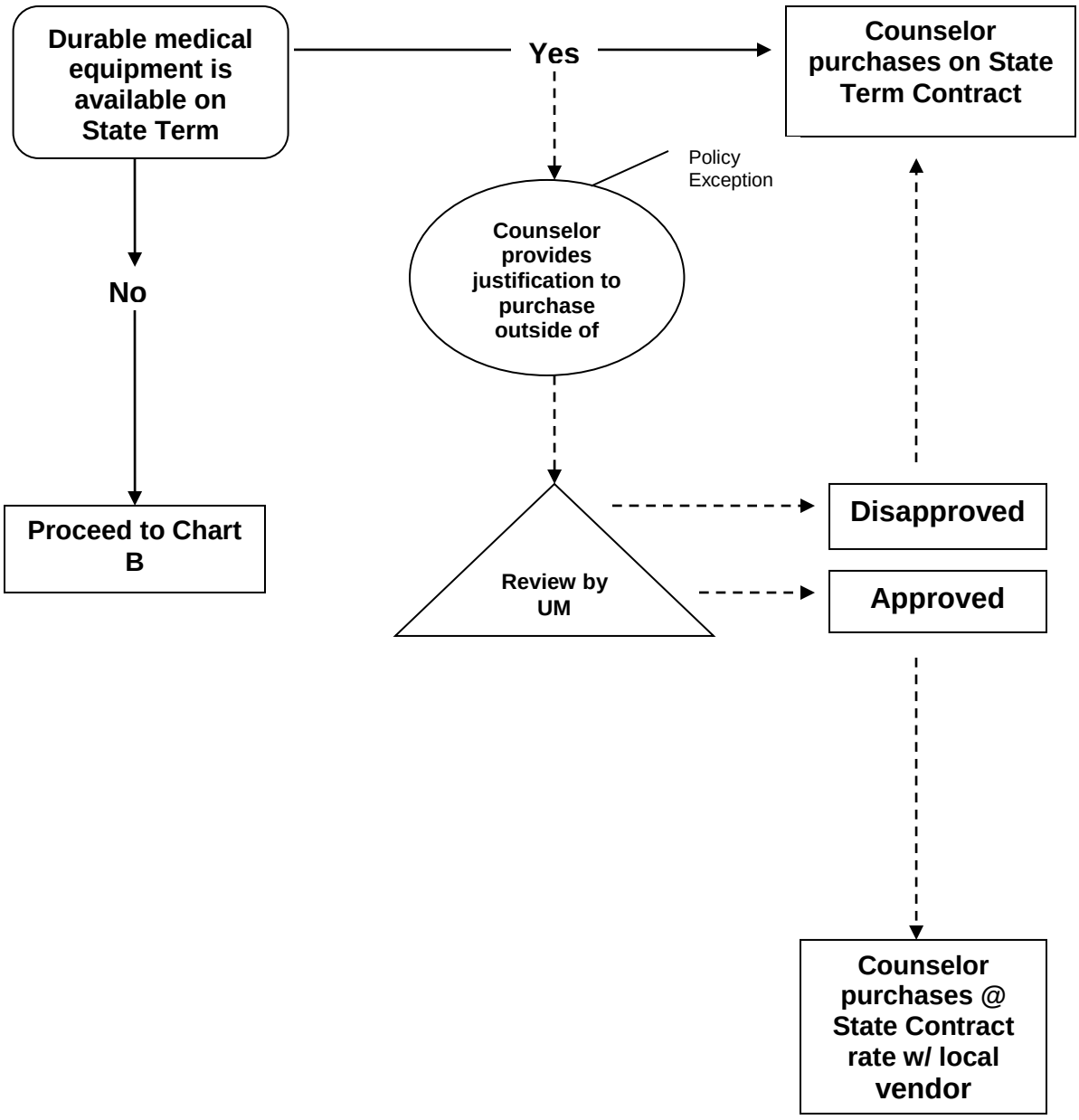
Furthermore, when authorizing, utilize the following codes as applicable:
Driver Training (No Adaptive Equipment): D,T 68
Driver Evaluation /Training (With/For Adaptive Equipment): D,T 69
Once the services are provided, the vendor is instructed (via DVR-0229-B) to submit their report, which will consist of a completed DVR-0229-D "Standardized Driving Evaluation /Training Report" and any additional information provided by the evaluator. In order to maintain the level of quality of the information within the reports, the counselor is to immediately send a legible copy of the report, signed case service and vendor invoices to your rehabilitation engineer, who will review and approve for payment via signature, date and title. Alternatively, your

engineer may request corrections to the report from the vendor prior to payment. The engineer will send the final report (if corrections were required) and the signed invoices to the counselor, who will submit the invoices to the controller's office for payment. PROCEDURES FOR OBTAINING DRIVING EVALUATION & TRAINING SERVICES WHEN ADAPTIVE DRIVING EQUIPMENT IS INVOLVED

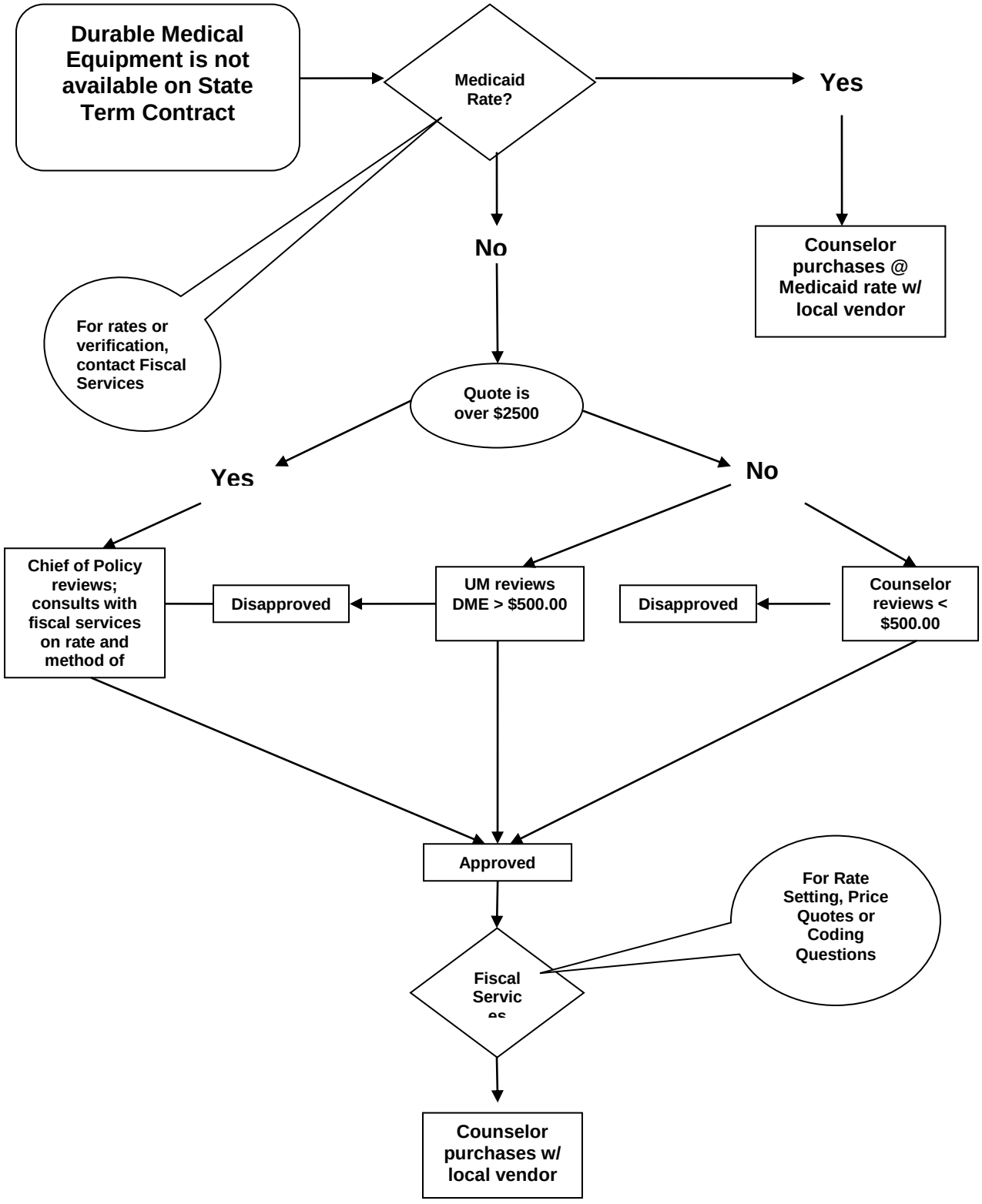
For future reference, the forms will be available via the following:

- VR Intranet site link:
http://hrdvr03.dvr.dhhs.state.nc.us/division/sections/pos/docs/resources.htm
- link from CATS to the VR Intranet site via "DrivingEvals" under the "Help" menu

Durable Medical Equipment: Purchase Procedures - Chart A



Durable Medical Equipment: Purchase Procedures - Chart B



Hearing Disabilities

Since hearing impairments present in varying degrees, the Division has developed specific criteria for the determination of an impairment based on a hearing loss. These criteria are designed to assist the service delivery staff in working with those individuals whose impairment is to such a degree that substantial impediments to employment may exist.

All VR clients with hearing disabilities, regardless of type and degree of hearing loss, must be served by the Rehabilitation Counselor for the Deaf unless it delays services. If clients with hearing disabilities are served by other counselors, the case must be staffed with the Rehabilitation Counselor for the Deaf. The Rehabilitation Counselor for the Deaf must always be consulted in the eligibility decision, the assessment of comparable benefits, and in the development of the IPE to ensure proper services are provided. Regular staffing should be documented in the case record. Bone Anchored Hearing Aids must be staffed with the Program Statewide Coordinator for Deafness and Communicative Disorders.

Establishing a Hearing Related Impairment

A hearing evaluation (audiogram) must be used to determine if a person has a hearing related impairment regardless of shelf life. For individuals who are deaf or are long-term users of hearing aids, an audiogram is sufficient for the establishment of an impairment and eligibility. However, depending on the discretion of the counselor, a new hearing evaluation can be authorized if a person has a progressive hearing loss or the counselor feels that a new hearing evaluation is needed.

Audiological Data and Purchases for VR and IL:

The Counselor **MUST NOT** purchase a hearing aid without updated audiological data that is less than one year old. (See 2-19-1 Hearing Aids) To be considered as valid audiological data, the medical information must include the type of hearing loss - sensorineural, conductive, mixed, or central; and the prognosis as to future development of the condition. Audiological data must include:

1. A statement from the otologist identifying the type of hearing loss or the identification of a progressive loss.
2. Medical clearance for fitting of an aid must be obtained from a physician skilled in diseases of the ear (ENT exam).
3. An audiogram with three-frequency pure tone average (PTA), speech discrimination (SD) scores, and the speech reception threshold (SRT) listed.
4. A narrative that provides a general description of the amplification device recommended and indicates the individual's preference regarding the device.

VR Policy for Hearing Related Impairment

A client is considered to have a hearing related impairment if **one** of the following criteria is met:

1. A **chronic** ear disease requiring medical treatment or surgery (not contingent upon decibel loss in either ear.); or
2. Average pure tone loss of 40 dB (ANSI) or more in the better ear in the speech range (500, 1,000, and 2,000 cycles per second) (UNAIDED); or
3. Average pure tone hearing loss of 20 dB (ANSI) or more in the better ear in the speech range when the pure tone average loss in the other ear exceeds 80 dB (ANSI)(UNAIDED); or
4. Regardless of the pure tone average loss, speech discrimination of less than 75% at 50-60 dB (average conversational intensity level) in the better ear in a quiet environment **(UNAIDED)**; or
5. A borderline chronic condition, which has been otologically and audiologically diagnosed as **rapidly progressive** and documented by a physician skilled in the diseases of the ear.

   "Rapidly progressive" is defined as having additional 10dB or more hearing loss in the better ear in the last year **either** with the pure tone average in the speech range (500, 1000, and 2000Hz)(UNAIDED)
   OR
   the other three frequencies (2000, 4000, and 6000Hz) (UNAIDED).

6. A **Cochlear implant (CI)** has been implanted in one ear; the client must also have one of the above 5 criteria listed above occurring with the second ear.

   An individual with a CI does meet the criteria for VR services if they already have an implant **and they meet the above criteria for hearing loss in the opposite ear**. If they have a CI and they meet the criteria for a hearing disability, the counselor must show documentation of **substantial impediments** to employment due to adjustment, residual perceptual problems or other impediments/problems related to the cochlear implant in order for the individual to be eligible for services. If they have an implant in one ear and normal hearing in the 2nd ear, they are not eligible. Any questions regarding eligibility, contact the Statewide Coordinator for Deafness and Communicative Disorders.

Independent Living Policy for Hearing Related Impairment

A client is considered to have a significant hearing disability if **ONE** of the following three criteria is met:

1. Speech Reception Threshold (SRT) of 55dB loss or more in the better ear in the speech range (500 Hz, 1000 Hz, and 2,000 Hz) (UNAIDED).

SRT is the softest level of sound at which a participant can correctly respond to at least 50% of a list of spondee (bi-syllabic) words.
2. Average pure tone loss of 55dB (ANSI) or more in the better ear in the speech range (500 Hz, 1000 Hz, and 2000 Hz) (UNAIDED).

For example, if the thresholds are 60dB at 500 Hz, 80dB at 1000 Hz, and 90dB at 2000 Hz. The pure tone average would be:

$\frac{60 + 80 + 90}{3} = \frac{230}{3} =$ 77dB (right ear)

$\frac{50 + 40 + 30}{3} = \frac{120}{3} =$ 40dB (left ear)

The most useful ear is the left and the person would not be eligible for IL services.

3. The Speech Reception Threshold (SRT) or the Pure Tone Average (PTA) is between 30-54 dB in the better ear plus one of the following:

a. Speech discrimination (SD) of less than 50% at 50-60 dB (average conversational intensity level) in the better ear in a quiet environment (UNAIDED).

OR

b. A statement from a physician skilled in diseases of the ear indicating a rapidly **progressive loss**.

"Rapidly progressive" is defined as having additional 10dB or more hearing loss in the better ear in the last year **either** with the pure tone average in the speech range (500, 1000, and 2000Hz)(UNAIDED)

OR

the other three frequencies (2000, 4000, and 6000Hz) (UNAIDED).

The above criteria must be considered in terms of the individual's ability to understand speech and communication in everyday situations, understanding of and adjustment to the hearing disability at home and work, and job safety considerations.

HIV/AIDS

Individuals with HIV as a primary impairment or secondary restoration issue must be diagnosed by a physician specializing in the assessment and medical management of this disease (i.e., infectious disease doctor). Counselors must use existing medical information when such is available or refer the individual to a physician as described above when the individual is without proper medical care. For individuals presumed eligible as a result of HIV or AIDS, as always, the counselor should try to obtain impairment-related data from the infectious disease professional that is providing treatment. The counselor may elect to staff the case with the unit medical consultant if it is deemed that the consultant can offer medical opinion or interpretation not otherwise available through the treating physician, however consultation with the unit medical consultant is not required.

IMPAIRMENT

The primary modes of transmission of HIV or Human Immunodeficiency Virus are unprotected sexual contact, intravenous drug use, exposure before and during birth and through breastfeeding, and the transfusion of blood and blood products[1]. Once an individual is exposed, the individual will either be HIV-positive, asymptomatic or HIV-positive, symptomatic. A person is diagnosed as having AIDS (Autoimmune Deficiency Syndrome) when the individual either (1) demonstrates the presence of an AIDS-defining disease (one of 24 opportunistic infections) and/or (2) demonstrates a CD4 cell count of less than 200[2]. Counselors should obtain current medical information which describes the viral load and CD4 count as well as symptoms in order to determine whether impediments to employment exist for an individual with HIV or AIDS.

HIV-Positive, Asymptomatic

The individual may demonstrate few to no symptoms. Symptoms during this phase may be similar to those found in other common communicable diseases and may include fatigue, unexplained weight loss, skin problems, bacterial pneumonia, and oral/vaginal thrush. Despite few symptoms, the virus is actively destroying the individual's immune system and can be transmitted to others as described above[2]. Since symptoms are transient, it is unlikely that an individual with asymptomatic HIV will present substantial impediments to employment as a result of the condition itself.

HIV-Positive, Symptomatic

During this phase, the individual's viral load increases and CD4 count (the amount of virus-fighting white blood cells) decreases. Therefore, the individual is

[1] Department of Health and Human Services, Center for Disease Control and Prevention: HIV/AIDS Topics. (2008, September 3). *How HIV Is and Is Not Transmitted.* Retrieved April 7, 2009 from http://www.cdc.gov/hiv/topics/basic/index.htm#transmission

[2] Berry, J. D., & Hunt, B. (2005). HIV/AIDS 101: A primer for vocational rehabilitation counselors. Journal of Vocational Rehabilitation, 22, 75-83.

less able to fight off communicable disease and opportunistic infections. Physical symptoms which may be present include: prolonged fever, night sweats, severe headache, persistent diarrhea, respiratory problems, problems with swallowing, vision problems, difficulty with sleeping and eating patterns, and pain[2]. In addition, the individual may experience cognitive and psychological symptoms including difficulty with concentration and short-term memory as well as comorbid depression[2]. Individuals may live as HIV-Positive, Symptomatic for decades before progressing to a diagnosis of AIDS. Individuals with symptomatic HIV can be considered for eligibility based on the individual's impediments to employment and ability to benefit from and need for a program of VR services.

AIDS

During this phase, an individual has very little resistance to communicable disease and is likely to have one or more serious opportunistic diseases including, but not limited to: cancer, tuberculosis, recurrent pneumonia, non-Hodgkin's lymphoma, Kaposi's sarcoma, AIDS dementia complex, and HIV wasting syndrome. It is often the complications of these opportunistic diseases which cause fatalities for individuals with AIDS. Individuals survive an average of two to four years following a diagnosis of AIDS; however some individuals have survived for more than 15 years following an AIDS diagnosis[2]. Individuals with AIDS may be considered for eligibility based on the individual's impediments to employment as well as their ability to benefit from and their need for a program of VR services.

IMPEDIMENT

HIV and AIDS are no longer considered terminal illnesses, but are viewed instead as chronic illnesses. Individuals with HIV or AIDS can experience periods of symptom exacerbations and remissions like other chronic illnesses. Therefore, careful consideration must be given to determine how an individual's illness presents impediments to employment. The following *may* represent impediments associated with HIV or AIDS:

- Difficulty with maintaining work schedule
- Difficulty with maintaining treatment regimen with required work demands
- Difficulty storing or administering medications in the workplace (need to have regular meals or snacks, need refrigeration, need private space to administer medications, etc.)
- Difficulty concentrating on the job
- Difficulty remembering job tasks or job functions
- Limited self-advocacy skills (related to disclosure issues and return-to-work fears)
- Difficulty maintaining motivation due to change in life values and inconsistencies with physical symptoms and response to treatment

- Comorbid disabling conditions and associated impediments to employment

Impediments to employment may vary widely from one individual to the next depending on the stage of the illness, the individual's assets, priorities, and concerns, and any comorbid conditions such as depression, substance abuse, or opportunistic diseases.

OTHER CONSIDERATIONS

Treatment

Currently, most individuals with HIV/AIDS are treated using HAART (highly active antiretroviral therapy). This is also called "combination therapy." Treatment results in various side effects including: nausea, headaches, dizziness, cognitive effects, rash, redistribution of body fat (increase in abdomen and decrease in face, buttocks, and extremities), diarrhea, peripheral neuropathy, and abdominal discomfort[2]. Individuals' responses to treatment vary. HAART involves a very strict treatment regimen where an individual takes many pills/injections a day with very specific indications. HAART requires extreme treatment adherence or the individual may develop a resistance to a class of medications, or, in the least, the effectiveness is minimized. Counselors should consider the vocational impacts of side effects from treatment as well as treatment adherence issues in determining eligibility and developing rehabilitation plans.

Disclosure

Whether to disclose an individual's diagnosis of HIV-positive or AIDS is a significant issue for individuals with these conditions because of the stigma which can be associated. Issues of disclosure should be taken into consideration with individuals with HIV/AIDS in terms of completing job applications and interviewing, requesting reasonable accommodation under ADA, requesting leave under FMLA, completing drug screenings, completing employer health questionnaires, and making decisions about health benefits. Only a few occupations require full disclosure, such as surgeons who perform invasive procedures, due to the risk for transmission. Otherwise, Counselors should assist clients with HIV/AIDS in identifying their functional limitations as well as training individuals to carefully consider job goals and to limit disclosure, including the request for workplace accommodations, to functional terms (i.e., Mr. Smith has a chronic illness which requires that he have access to a private place to administer his treatment regimen and that he have a modified schedule which begins no earlier than 10:00 AM.). For individuals whose employers require them to complete health questionnaires due to the nature of the work performed, one strategy is to request that the treating physician write a summary of the individual's functional needs and/or limitations or a statement summarizing the lack of impact of the illness on the items addressed in the health questionnaire as

a substitute for completing a health questionnaire which has items that may subject the individual to disclosing his/her HIV/AIDS diagnosis[3].

Further, some forms of combination therapy will result in a positive drug screen for marijuana. The likelihood for testing a false-positive does not require that a person with HIV/AIDS disclose his/her condition to an employer. Typically, a Medical Review Officer with the drug testing company will request legal proof of prescription. This information is not shared with the employer. If the Medical Review Officer verifies that the medication is the cause of the positive test result, the result is reported to the employer as negative [3,4].

Resources

For more information on HIV/AIDS, resources, and treatment locations, visit the websites below:

The NC Department of Health and Human Services Epidemiology Section link to HIV/STD Prevention and Care:
http://www.epi.state.nc.us/epi/hiv/index.html

Project Inform link to NC HIV/AIDS resource list:
http://www.projectinform.org/info/state/NC.shtml

The Body: The Complete HIV/AIDS Resource:
http://www.thebody.com/index.html

US Department of Health and Human Services AIDSinfo:
http://aidsinfo.nih.gov/

US Department of Health and Human Services AIDS.gov:
http://www.aids.gov/

Centers' for Disease Control National Prevention Information Network Organization Search Engine:
http://www.cdcnpin.org/scripts/search/orgSearch.aspx

[3] Breuer, N. L. (2005). Teaching the HIV-positive client how to manage the workplace. Journal of Vocational Rehabilitation, 22, 163-169.

[4] Pietrandoni, G. (2000, September/October). Back to Work Drug Screenings. *Positively Aware.* Retrieved April 7, 2009, from http://www.tpan.com/publications/positively_aware/sept_oct_00/back_to_work_drug_screen.html

IL Federal Service Definitions

The definitions below are provided by federal regulations established for the Independent Living Programs. The IL Program is required to report services provided to IL clients in one of the following service categories. These definitions are not intended to supplant those specific policies outlined in Chapter 2 of this manual. However, in order to provide consistency in Federal reporting, the categories below are the only options available when selecting service labels in the Division's electronic case management system. Therefore, all services provided under policies in Chapter 2 must be selected on the IPIL and reported within one of the categories below:

Assistive Devices/Equipment
Provision of specialized devices and equipment such as wheelchairs, tub transfer benches, personal lifts, TDDs, or the provision of assistance to obtain these devices and equipment from other sources.

Communication Services
Services to enable consumers to better communication such as interpreter services, training in communication equipment use, Braille instruction, and reading services.

Counseling Services
Services including psychological, psychotherapeutic, and related services.

Family Services
Services provided to the family members of an individual with a significant disability when necessary for improving the individual's ability to live and function more independently, or ability to engage or continue in employment. Such services may include respite care.

Housing, Home Modification and Shelter
Services related to securing housing or shelter or modifying existing housing.

Information and Referral
Services provided to a consumer to assist with identifying and locating additional resources. This would include transition to Vocational Rehabilitation.

Mobility Training
Services involving assisting consumer to get around their homes and communities such as gait training or training in how to utilize public transportation.

Other

Any IL service not included in a specific service category.

Personal Assistance Services
Services including personal assistance and personal assistance management training.

Physical Rehabilitation
Restoration services including physical therapy; occupational therapy; speech, language or hearing therapy; and/or eye glasses and visual services.

Prosthetics/Orthotics
Services including prosthetic, orthotic, and other assistive applicances and devices.

Recreational Services
Services to provide opportunities for the involvement of consumers in meaningful leisure-time activities. May include such things as participation in community affairs or other activities of a competitive, active or quiet nature.

Rehabilitation Technology
Services provided through the systematic application of technologies, engineer methodologies, or scientific principles to address barriers confronted by consumers with significant disabilities. Engineer services, vehicle modifications, and seating clinics are included in this service.

Transportation
Provision of or arrangement of transportation for completion of other goals/services.

Vocational Services
Any services provided to obtain, maintain, or advance in employment.

[CFR 364.4]

Intellectual Disability

In order to be classified as an individual with an intellectual disability for vocational rehabilitation purposes, the individual must have significant subaverage intellectual functioning defined as a FSIQ of 74 or less. Regardless of FSIQ scores, adaptive behavior deficits are critical elements in determining eligibility on the basis of intellectual disability. The FSIQ score along with deficits in adaptive behavior provide documentation of an impairment. When an intellectual disability is the major disability, the FSIQ must be recorded on the DVR-0004 and entered into the CLIENT DATA BASE. The following FSIQ ranges will be used:

- Mild - FSIQ range of 55-74.
- Moderate - FSIQ range of 40-54.
- Severe - FSIQ range of 25-39.

If the psychologist reports the FSIQ range rather than the actual score, the counselor should report the mid-point of the range, i.e. Mild - 65, Moderate - 47, Severe - 32

Learning Disability

Learning Disabilities (defined as “learning disorder” in the DSM-IV) are diagnosed when the individual's achievement on individually administered, standardized tests in reading, mathematics, or written expression is substantially below that expected for age, schooling, and the level of intelligence. The learning problems must significantly interfere with academic achievement or activities of daily living that require reading, mathematical, or writing skills.

Learning Disabilities vary in severity, as do all disabilities. In both categories I and II below, it is the counselor’s responsibility to review all available information regarding the individual’s work history, extra-curricular activities, overall skills, aptitudes, interests, and achievement in secondary school. This information should be considered to determine if the individual’s learning disability represents an impediment to employment and to assist the individual in planning for a job choice that is appropriate to his or her capabilities. Under no circumstances will the Division sponsor remedial services while the individual is enrolled in secondary school.

CATEGORY 1: The following criteria will apply to:

- Students enrolled in the public school system or public charter school with an Individualized Education Program (IEP) for the current year developed to address the individual’s learning disability.
- Individuals who have been out of public school less than two years and were identified as disabled with an IEP during the last year of enrollment developed to address a learning disability.

Impairment
The learning disability as an impairment must be documented by obtaining a copy of the Learning Disabilities Eligibility Report, which includes the psychological and educational evaluation and a copy of the IEP Team Report recommending the individual’s identification as having a learning disability and in need of special education services.

Determination of Substantial Impediment(s)
Emphasis should be on the identification of the impediments to employment caused or created by the impairment. The following criteria apply and must be documented:

Scores on an individually administered achievement test in reading, mathematics, or written expression indicate that the applicant's achievement score is below grade level. Achievement scores must be at least three grade levels below current grade placement with a maximum achievement level of 8.0

grade level in the 11th grade, the 12th grade and the two years after exiting school. The following criteria apply and must be documented:

- Ninth grade level (9.0-9.9) students must score 6.9 or below on achievement tests.
- Tenth grade level (10.0-10.9) students must score 7.9 or below on achievement tests.
- Eleventh grade level students must score below 8.0 on achievement tests.
- Twelfth grade level students must score below 8.0 on the achievement tests.
- Students who are referred within two years of exiting school must score below 8.0 on achievement tests.

Utilization of achievement data is a required component of all referrals for Vocational Rehabilitation Services. In order to avoid unnecessary testing, existing data from previously administered achievement tests may be used if the most recent achievement score(s) were obtained within two years of the application for services. Otherwise, current achievement data must be secured from a vocational evaluator or other sources. Achievement scores from the Wide Range Achievement Test (WRAT) will not be accepted for purposes of eligibility.

AND

The student is currently receiving at least three supplemental aides during this academic year (or received them during the last year of school) as stated on the IEP and/or through verification from the individual, parent or school system personnel. A copy of the IEP should be included in the case record. The following list is not intended to be an exhaustive list of possible supplemental aides or services:

- Note taker services
- Oral testing
- Additional support from a teacher assistant
- Job coach
- Enrollment in exceptional children curriculum support class
- Tutorial services
- Enrollment in exceptional children resource room
- Extended test time
- Abbreviated assignments
- Assistive devices
- Requires the use of audiotapes for instruction

CATEGORY 2:

For those individuals who do not meet Category I criteria, a psychologist using the current Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria, must document the learning disability, which establishes the existence of impairment. Also, the psychologist must provide scores on an individually administered achievement test in reading, mathematics, or written expression. Achievement test scores from the Wide Range Achievement Test (WRAT) will not be accepted for purposes of eligibility.

Determination of Substantial Impediment(s)
As in all cases, emphasis should be on identification of the functional limitations which are imposed by the impairment and which establish the impediment to employment. Scores on an individually administered achievement test must be at or below the 8.0 grade level in reading, math, or written expression. The analysis by the counselor must demonstrate that the diagnosis of LD results in substantial impediments to employment, examples of which could include:

- The learning disability has resulted in the individual being impeded in obtaining job skills and experiences commensurate with his/her abilities.
- The individual has lost employment or experienced difficulty on jobs or in post-secondary training programs because of an inability to access written training materials or perform written or computational job requirements, etc.

In instances where the diagnosis is indicated as Learning Disabled, Not Otherwise Specified (LD-NOS), these cases must be reviewed on an individual case-by-case basis in determining the existence of substantial impediments to employment.

Personal Assistance Services Calendar 2009-2010 (Staff Use Only)				
BEGINNING DATE	**ENDING DATE**	**DUE DATE TO DVRS OFFICE**	**DUE DATE TO CONTROLLER'S OFFICE**	**ESTIMATED PAY DATE**
12/3/2009	12/16/2009	12/21/2009	12/23/2009 By Noon	1/2/2010
12/17/2009	12/30/2009	1/4/2010	1/8/2010	1/16/2010
12/31/2009	1/13/2010	1/18/2010	1/22/2010	1/30/2010
1/14/2010	1/27/2010	2/1/2010	2/5/2010	2/13/2010
1/28/2010	2/10/2010	2/15/2010	2/19/2010	2/27/2010
2/11/2010	2/24/2010	3/1/2010	3/5/2010	3/13/2010
2/25/2010	3/10/2010	3/15/2010	3/19/2010	3/27/2010
3/11/2010	3/24/2010	3/29/2010	4/1/2010	4/10/2010
3/25/2010	4/7/2010	4/12/2010	4/16/2010	4/24/2010
4/8/2010	4/21/2010	4/26/2010	4/30/2010	5/8/2010
4/22/2010	5/5/2010	5/10/2010	5/14/2010	5/22/2010
5/6/2010	5/19/2010	5/24/2010	5/28/2010	6/5/2010
5/20/2010	6/2/2010	6/7/2010	6/11/2010	6/19/2010
6/3/2010	6/16/2010	6/21/2010	6/23/2010 By Noon	7/3/2010
6/17/2010	6/30/2010	7/5/2010	7/9/2010	7/17/2010
7/1/2010	7/14/2010	7/19/2010	7/23/2010	7/31/2010
7/15/2010	7/28/2010	8/2/2010	8/6/2010	8/14/2010
7/29/2010	8/11/2010	8/16/2010	8/20/2010	8/28/2010
8/12/2010	8/25/2010	8/30/2010	9/3/2010	9/11/2010
8/26/2010	9/8/2010	9/13/2010	9/17/2010	9/25/2010
9/9/2010	9/22/2010	9/27/2010	10/1/2010	10/9/2010
9/23/2010	10/6/2010	10/11/2010	10/15/2010	10/23/2010
10/7/2010	10/20/2010	10/25/2010	10/29/2010	11/6/2010
10/21/2010	11/3/2010	11/8/2010	11/12/2010	11/20/2010
11/4/2010	11/17/2010	11/22/2010	11/24/2010	12/4/2010
11/18/2010	12/1/2010	12/6/2010	12/10/2010	12/18/2010
Personal Assistance Definitions & Resources				

The provision of personal assistance services requires that the IL client be established as a household employer of his/her own personal assistant(s). Therefore, the client is required to adhere to tax laws specific to household employers. DVRS is not responsible for any penalties which would result if the client is delinquent in paying employer related taxes. Any and all correspondence with the Federal Internal Revenue Service or NC Employment Security Commission is the client's sole responsibility. Clients may obtain assistance in understanding their employer-related obligations from the Internal Revenue Service or NC Employment Security Commission. DVRS, including the client's counselor, will not advise the client on employer-related obligations or in completing the required paperwork for reporting and payment of the federal/state household employer taxes.

Household Employer Terms

Federal Household Employer ID:	Unique nine-digit number that the client obtains from the Internal Revenue Service; also called the Employer Identification Number (EIN).
FICA Taxes:	Taxes established under the Federal Insurance Contributions Act. These are federal taxes required of employees, and matched by employers, to fund the Social Security and Medicare programs. FICA must be computed and paid for each employee and applies to each personal assistance client and the assistant(s) the client employs. FICA rates are subject to adjustment by the Internal Revenue Service (IRS), effective in January of any given year. The current FICA rate is found in Volume V. FICA tax is broken into two (2) separate but equal parts - employer (client) contribution and employee (assistant) contribution. The employer (client) is responsible for one-half of the overall FICA tax, and the employee (assistant) is responsible for the other half. The employee's portion is withheld by the employer from the assistant's gross pay each pay period. The formula for both the employer and employee share of FICA tax is: FICA TAX = FICA TAX RATE x GROSS PAY. FICA taxes are paid either quarterly or annually depending on the anticipated amount of tax owed during a calendar year. The client is responsible for reporting to the Division whether the client is required to pay FICA taxes annually or quarterly.
Form NCUI-101:	NC Employment Security Commission Form by which the client files his/her SUTA taxes each quarter.

Form NCUI-104:	NC Employment Security Commission Form entitled, "Unemployment Tax Rate Assignment," by which the client is notified of his/her SUTA Rate. A copy of the form must be provided to the Division by December 15 of each year.
Form SS-4	Form client receives from the IRS with federal employer ID number.
Form W-2, Wage and Tax Statement:	The IRS form completed by the client and given to the client's assistant(s) to file with the IRS to report the employer FICA taxes owed for each employee.
Form W-3, Transmittal of Income and Tax Statement:	The IRS form filed by the client with the Social Security Administration to report the employer FICA taxes owed for each employee when an employer has more than one employee.
FUTA Taxes:	Taxes imposed by the Federal Unemployment Tax Authority. This authority rests with the Internal Revenue Service (IRS). The FUTA rate may change at the beginning of the calendar year, but it is the same for all employers. The current FUTA rate may be found in Volume V. Wages over a certain annual threshold, per employee, are not taxed for FUTA purposes. FUTA taxes are paid annually.
Gross Pay:	Total remuneration owed to an employee prior to withholdings or deductions. The formula for gross pay for each assistant employed is: GROSS PAY = EMPLOYEE SHARE FICA + NET PAY to EMPLOYEE.
Household Employer:	An individual who employs a household worker to perform work at the direction of the individual (i.e., directs the worker in what the worker will do and how and when the worker will do it).
Net Pay:	The employee's "take home" pay once the employee's share of FICA taxes have been withheld. The formula for net pay is: NET PAY = GROSS PAY – *(minus)* EMPLOYEE SHARE FICA.
Qualifying Quarter:	A quarter, in the North Carolina tax year, in which the combined gross pay paid to all employees of the household employer is equal to or greater than $1000.
Reimbursement Rate:	Includes the total funds paid to the client, including assistant hourly wage and applicable employer taxes, in order to employ the assistant(s). The formula for reimbursement rate for the client is: REIMBURSEMENT RATE = GROSS PAY + EMPLOYER FICA + FUTA + SUTA (if applicable).
Schedule H:	IRS form which must be filed by the client to file FICA and FUTA taxes by March 15th of each year.
State Household Employer ID:	Unique nine-digit identification number that the client obtains from the NC Department of Revenue.

SUTA Taxes:	Taxes imposed by the State Unemployment Tax Authority. In North Carolina, this authority is the Employment Security Commission (ESC). The SUTA rate varies for each individual employer (client) based on the given calendar year and is subject to change effective January 1 of each year. The NC ESC will provide the client with a copy of their SUTA Tax Rate upon request. SUTA taxes are paid quarterly if the employer exceeds a certain quarterly threshold for gross wages paid to all employees. The current threshold is found in Volume V.

Household Employer Resources

Because the client is responsible for carrying out all responsibilities of a household employer, the Division shall direct the client to resources specific to this role. These include:

Internal Revenue Service (IRS)
www.irs.gov
1-800-829-1040

NC Employment Security Commission (visit website for local office contact information)
www.ncesc.com

NC Department of Revenue
www.dornc.com
1-877-252-3052

IRS Publication 926, Household Employer's Tax Guide: This guide defines the federal roles and responsibilities of a household employer including a description of the tax forms which need to be filed by the employer.

IRS Publication 525, Taxable and Non-Taxable Income: This publication indicates that reimbursements received by the client in order to employ a household worker to provide personal assistance is not considered taxable income.

20 CFR §416.1103: This is the citation of the Federal Code pertaining to the Social Security Administration which also defines personal assistance reimbursements as non-taxable income.

Personal Assistance Services: Processing Federal and State Quarterly and Annual 2010 Taxes (IL Staff Use Only)

Below outlines the pay periods to be included when calculating the federal and state quarterly and annual taxes for the VR/IL participant receiving personal assistance service and who is the employer of their assistant(s). The date to submit the case service invoice to the Controller's Office and payment date to the IRS and Employment Security Commission is also included in the information below.

First Quarter Taxes

SUTA Tax

- Pay periods to be included in the first quarter SUTA tax are 12/3/09 - 12/16/09 through 2/25/10 - 3/10/10.
- Calculate the first quarter SUTA tax on 3/22/10 and submit the case service invoice to the Controller's Office by Friday, March 26, 2010.
- Do not give the client the SUTA tax if the personal assistant is the parent, spouse or child under the age of 21.
- Put the word "SUTA" next to the SUTA amount on the case service invoice.
- The SUTA tax is due to the Employment Security Commission by Friday, April 30, 2010.
- The Form DVR-1022B is due to the IL Office by May 7, 2010.

FICA Tax

- Pay periods to be included when calculating the first quarter FICA tax are 12/3/09 - 12/16/09 through 2/25/10 - 3/10/10.
- Calculate the first quarter FICA tax by adding the FICA tax (employer and employee) portions together for the seven pay periods to obtain the total FICA amount.
- Calculate the first quarter FICA tax after you have processed the 2/25/10 - 3/10/10 pay period and submit the case service invoice to the Controller's Office by Friday, March 19, 2010.
- Do not give the client the FICA tax if the personal assistant is the parent, spouse or child under the age of 21.
- The FICA tax needs to be on a separate case service invoice and put the word "FICA" next to the total amount.
- The FICA tax is due to the IRS by Thursday, April 15, 2010.
- The Form DVR-1022B is due to the IL Office by April 22, 2010.

Second Quarter Taxes

SUTA Tax

- Pay periods to be included when calculating the second quarter SUTA tax are 3/11/10 – 3/24/10 through 5/20/10 – 6/2/10.
- Calculate the second quarter SUTA tax on 6/14/10 and submit the case service invoice to the Controller's Office by Friday, June 18, 2010.
- Do not give the client the SUTA tax if the personal assistant is a parent, spouse or child under the age of 21. If the child turned 21 during this quarter, then give the client the SUTA tax for this quarter, the previous quarter and all remaining quarters.
- Put the word "SUTA" next to the SUTA amount on the case service invoice.
- The SUTA tax is due to the Employment Security Commission by Friday, July 30, 2010.
- The Form DVR-1022B is due to the IL Office by August 6, 2010.

FICA Tax

- Pay periods to be included when calculating the second quarter FICA tax are 3/11/10 – 3/24/10 through 4/22/10 – 5/5/10.
- Calculate the second quarter FICA tax by adding the FICA tax (employer and employee) portions together for the four pay periods to obtain the total FICA amount.
- Calculate the second quarter FICA tax after you have processed the timesheet(s) for the 4/22/10 – 5/5/10 pay period and submit the case service invoice to the Controller's Office by Friday, May 14, 2010.
- Do not give the client the FICA tax if the personal assistant is a parent, spouse or child under the age of 21. If the child turned 21 during this quarter, then give the client the FICA tax for this quarter, the previous quarter and all remaining quarters.
- The FICA tax needs to be on a separate case service invoice and put the word "FICA" next to the total amount.
- The FICA tax is due to the IRS by Tuesday, June 15, 2010.
- The Form DVR-1022B is due to the IL Office by June 22, 2010.

Third Quarter Taxes

SUTA Tax

- Pay periods to be included when calculating the third quarter SUTA tax are 6/3/10 – 6/16/10 through 8/26/10 – 9/8/10.
- Calculate the third quarter SUTA tax on 9/20/10 and submit the case service invoice to the Controller's Office by Friday, September 24, 2010.

- Do not give the client the SUTA tax if the personal assistant is a parent, spouse or child under the age of 21. If the child turned 21 during this quarter, then give the client the SUTA tax for this quarter, the previous quarters and remaining quarter.
- Put the word "SUTA" next to the SUTA amount on the case service invoice.
- The SUTA tax is due to the Employment Security Commission by Friday, October 29, 2010.
- The Form DVR-1022B is due to the IL Office by November 5, 2010.

FICA Tax

- Pay periods to be included when calculating the third quarter FICA tax are 5/6/10 - 5/19/10 through 7/29/10 – 8/11/10.
- Calculate the third quarter FICA tax by adding the FICA tax (employer and employee) portions together for the seven pay periods to obtain the total FICA amount.
- Calculate the third quarter FICA tax after you have processed the timesheet(s) for the 7/29/10 – 8/11/10 pay period and submit the case service invoice to the Controller's Office by Friday, August 20, 2010.
- Do not give the client the FICA tax if the personal assistant is a parent, spouse or child under the age of 21. If the child turned 21 during this quarter, then give the client the FICA tax for this quarter, the previous quarters and remaining quarter.
- The FICA tax needs to be on a separate case service invoice and put the word "FICA" next to the total amount.
- The FICA tax is due to the IRS by Wednesday, September 15, 2010.
- The Form DVR-1022B is due to the IL Office by September 22, 2010.

Fourth Quarter Taxes

SUTA Tax

- Pay periods to be included when calculating the fourth quarter SUTA tax are 9/9/10 – 9/22/10 through 11/18/10 - 12/1/10.
- Calculate the fourth quarter SUTA tax after you have processed the timesheet(s) for the 11/18/10 - 12/1/10 pay period and submit the case service invoice to the Controller's Office by Friday, December 10, 2010.
- Do not give the client the SUTA tax if the personal assistant is a parent, spouse or child under the age of 21. If the child turned 21 during this quarter, then give the client the SUTA tax for this quarter and the previous quarters.
- The SUTA tax can be put on the same case service invoice that is used for the FICA and FUTA taxes. Put the word "FICA", "FUTA" and "SUTA" next to each total amount.
- The fourth quarter SUTA tax is due to the Employment Security Commission by Monday, January 31, 2011.
- The Form DVR-1022B is due to the IL Office by February 7, 2011.

FICA Tax

- Pay periods to be included when calculating the fourth quarter FICA tax are 8/12/10 – 8/25/10 through 11/18/10 - 12/1/10.
- Calculate the fourth quarter FICA tax by adding the FICA tax (employer and employee) portions together for the eight pay periods to obtain the total FICA amount.
- Calculate the fourth quarter FICA tax after you have processed the timesheet(s) for the 11/18/10 - 12/1/10 pay period and submit the case service invoice to the Controller's Office by Friday, December 10, 2010.
- Do not give the client the FICA tax if the personal assistant is a parent, spouse or child under the age of 21. If the child turned 21 during this quarter, then give the client the FICA tax for this quarter and the previous quarters.
- The FICA tax can be put on the same case service invoice that is used for the SUTA and FUTA taxes. Put the word "FICA", "FUTA" and "SUTA" next to each total amount.
- The fourth quarter FICA tax is due to the IRS by Tuesday, January 18, 2011.
- The Form DVR-1022B is due to the IL Office by January 25, 2011.

Annual FICA and FUTA Tax

- Pay periods to be included when calculating the annual FICA and FUTA taxes are 12/3/09 - 12/16/09 through 11/18/10 - 12/1/10.
- Calculate the annual FICA and FUTA taxes after you have processed the timesheet(s) for the 11/18/10 - 12/1/10 pay period and submit the case service invoice to the Controller's Office by Friday, December 10, 2010.
- Do not give the client the FICA and FUTA taxes if the personal assistant is a parent, spouse or child under the age of 21. If the child turned 21 during this year, then give the client the FICA and FUTA taxes for the year.
- The annual FICA and FUTA taxes can be put on the same case service invoice that is used for the fourth quarter SUTA tax. Put the word "FICA", "FUTA" and "SUTA" next to each total amount.
- The annual FICA and FUTA Taxes are due to the IRS by April 15, 2011.
- The Form DVR-1022B is due to the IL Office by April 22, 2011.

Please contact Cynthia Temoshenko, Program Specialist, DVRS, at (919)855-3525 or cynthia.temoshenko@dhhs.nc.gov if you have questions.

Referral - Script

The following script shall be used when introducing any potential applicants to the VR/IL process. Office staff responsible for providing phone coverage should become familiar with and use the script when potential applicants call or present in person. This language needs to be used in any written materials that are made available to the public in explaining our referral process, including letters to parents of students.

In order to become an applicant for services with the NC Division of Vocational Rehabilitation, you must be available to participate in assessments for purposes of determining your eligibility, rehabilitation needs and services. Individuals in the following circumstances are <u>not</u> considered available for participation in services:

1. *Have outstanding warrants for arrest and/or pending charges that would prevent the individual from participating in a program of vocational rehabilitation services.*
2. *Cannot/or are unwilling to attend appointments and evaluations.*
3. *Are unwilling to participate in essential disability related treatment that will enable an individual to benefit from Division services in terms of an employment outcome.*

As a division of North Carolina state government, Vocational Rehabilitation is required to comply with any orders on file from the NC Department of Justice for reporting individuals having outstanding warrants to the appropriate authorities. A criminal check is done on all referrals before they come to a VR office. Please take this into account when you make a decision to come to our office.

In order to maintain a safe and supportive environment for our staff and consumers, we ask that you comply with the Division's Code of Conduct which is posted in all unit offices and printed in your application materials.

Rehabilitation Counselor II Process

North Carolina
Department of Health and Human Services
Division of Vocational Rehabilitation Services

Beverly Eaves Perdue, Governor
Lanier M. Cansler, Secretary

LOCATION:
805 Ruggles Drive
Raleigh, NC 27603

Linda S. Harrington, Director

MAILING ADDRESS:
2801 Mail Service Center
Raleigh, NC 27699-2801
Courier # 56-20-07

MEMORANDUM

To: All Field Staff

From: Linda S. Harrington, Director

Subject: Revised Rehabilitation Counselor II Process - Removal of the Written/Oral Examination from the Rehabilitation Counselor II Process

Date: February 19, 2009

Effective immediately, the written/oral examination is removed from the Rehabilitation Counselor II process. All other requirements and provisions of the X policy remain in effect, including the casework review. For future reference, this memo will be attached to the policy on the Human Resources web page, and will be posted in the Volume I Appendix. If there are any questions regarding how this revision affects Counselor's currently undergoing the evaluation process for Rehabilitation Counselor II, please consult your Unit Manager and/or Regional Director for guidance.

Substance Abuse

When obtaining an evaluation for alcohol or drug abuse in the determination of eligibility for services and rehab needs, Counselors should utilize Psychologists, Licensed Psychological Associates, Psychiatrists, or Physicians who are certified in the area of substance abuse or affiliated with a licensed alcohol and/or drug treatment program, or Licensed Clinical Addictions Specialists (LCAS).* Evaluations from public or private treatment programs may be utilized if the evaluations are carried out or supervised by one or more of these specialties. Counselors should assure the evaluative data is current enough to establish the existence of an impairment that results in impediments to employment. The evaluation should include:

- A history of the disorder including a detailed description of the nature and severity of the addiction; response to previous treatment efforts if attempted or completed: evidence that the individual has accepted the reality of the addiction and is willing to take responsibility for ongoing treatment and/or support programs as recommended.
- Recommendations as to treatment (inpatient or outpatient) and/or community support systems necessary to ensure continued recovery.

***Note:** Staff of the Division having any of the above credentials are prohibited from diagnosing and providing treatment to individuals served by the Division of Vocational Rehabilitation Services. For questions about secondary employment contact the Human Resources Section of NC DVR.

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